

INTERCULTURALITY FROM BELOW: A STUDY OF MATERNAL HEALTH ENCOUNTERS IN THE PERUVIAN ANDES

**Thesis submitted in accordance with the requirements of the
University of Liverpool for the degree of Doctor in Philosophy**

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March 2018

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Abstract

Interculturality from Below: A Study of Maternal Health Encounters in the Peruvian Andes

Across the Peruvian Andes, rural women continue to die in childbirth. Since 2009, Peru's Ministry of Health has promoted a policy of *parto institucional* (clinically managed birth) in an attempt to lower the maternal mortality ratio (MMR) in the Sierra. Andean women have historically given birth at home, leading the Ministry of Health to position high MMR across the Andes as a 'cultural' problem. Introducing a series of intercultural health initiatives, the Ministry of Health encourages Andean women to deliver in designated health clinics. Obstetricians are instructed to respect women's cultural preferences, offering *parto vertical* (upright delivery) birthing techniques, whilst at the same time, the work of the community *partera* (midwife) is marginalised by the state. Despite a significant rise in the number of clinically managed births, MMR in the Andes remains higher than in urban areas of the country. Cultural assumptions built around historic preferences for home births have thus influenced policy measures, significantly impacting on the maternal health choices available to rural women.

This thesis seeks to challenge the cultural assumptions underpinning the Ministry of Health's current maternal health policy. Rather than focusing on the 'cultural problem', this study centralises the practices and understandings of the social actors involved in maternal health. Taking an ethnographic perspective, this thesis examines maternal health encounters as they are lived out in local context by rural women and the practitioners attending to them.

This thesis shows that maternal health in the Andes is not just experienced in the consultation rooms and delivery suites of obstetric departments, but also in the homes, and across the diverse and challenging geographical terrains that make up the routines and everyday lives of rural women. The difficulties of reconciling a rural, agricultural lifestyle with the demands of maternal health policy require that women travel long distances over extended periods of time to attend health clinics. Family dynamics, and pragmatic and logistical concerns are very real and pressing concerns for pregnant women in the Andes today. Situating maternal health interventions in local context, this thesis exposes the biopolitical arrangements that shape women's maternity. It shows how culture is mobilised to ensure that rural women – and the practitioners charged with their care – conform to social and institutional expectations. In order to fully understand Peru's maternal health 'problem' then, we must situate it within the local contexts and lived experiences in which it is firmly embedded.

Declaration

This thesis is the result of my own work. The material contained in this thesis has not been presented, nor is currently being presented, either in part or wholly for any other degree qualification.

I was solely responsible for all data collection and analysis.

Acknowledgements

In the eight years that it has taken me to complete this doctoral thesis a lot has happened in my life. The best thing that happened to me was that I became an Auntie twice and the saddest thing was losing my mam suddenly and unexpectedly. Throughout this roller coaster ride, a lot of people have kept me on track, encouraging and reassuring me that one day I would eventually complete this piece of research. I would like to thank them below.

First and foremost my sincere gratitude must go to my wonderful supervisors. Dr. Ciara Kierans has been an inspiration throughout and I have absolutely no doubt that without her unwavering academic, moral and emotional support and brilliant intellectual guidance I would not be writing this today. Dr. Debbi Stanistreet has also been a great support, persuading a naive but enthusiastic secondary school teacher that a PhD in public health was absolutely a great idea, and going above and beyond the call of duty, providing board and lodging on my visits to the University on many occasions. I would also like to thank Professor Sue Higham for her advice and support during the times when difficult personal circumstances forced me to suspend my studies.

I must also thank my dear friend Dr. Melania Calestani for proof reading and advice during earlier drafts of this thesis. My long standing (and long suffering!) friend Tian Bersey deserves a special mention for late night proof reading, reference checking and just generally listening patiently to it being ‘all about me’ in the final weeks prior to submission.

I would also like to thank my family. A very big thank you to my “Magic Daddy”, Peter, for raising me to believe in myself and have the courage to do whatever I wanted to do in my life, to my “sista” Louise (proper name, look!) for smiling all the way through the last year, even when we were crying around you. Last but not least, a big kiss to my naughty nieces “Ning” and “Bobess”, thanks for all the emojis sent with such love from your Ipads. ☺

I have to send a massive hug to my boyfriend Kam, for always being there for me. I don’t know where I would be without you my dear, but it would probably involve being stranded at Heathrow Terminal 5 in the middle of the night or missing a flight because of the Queen’s Speech.

Thank you to my adopted family in Peru and all my Peruvian friends who have been such an important part of my life since I first visited their wonderful country in 2005: *abrazotes para Rosy, mi querida HP, y Bitá, mi abuelita chiclayana, y también para Pati, Shirley, Yudy y Janeth en Cusco. Gracias a Claudio por facilitar mi estancia en Chiara y a todos los chierinos quienes me cuidaron mucho; a la Doctora Jeannette, la obstetra Janeth y el Doctor Grover por aguantar mis muchas preguntas y entrevistas interminables.*

Last but not least, thanks to my best friend Cristina Sánchez. I know Liverpool is ‘up North’ *Jefi*, but it will be alright in the end. Remember, if it’s not alright yet, it’s not the end yet.

Dedication

This thesis is dedicated to the memory of my lovely mammy,

Patricia Elizabeth Moore.

Glossary

Abbreviations

ACS	Agente Comunitario de Salud (Community Health Agent)
AUS	<i>Aseguramiento Universal de Salud</i> (Universal Health Insurance)
CLAS	<i>Comunidad Local Administrativa de Salud</i> (Local Community Health Administration)
CRED	<i>Crecimiento y Desarrollo</i> (Growth and Development): Health check for Under 5's
DIRESA	<i>Directorio Regional de Salud</i> (Regional Health Directorate/Authority)
DNI	<i>Documento Nacional de Identidad</i> (National Identity Card)
EmOC	Emergency Obstetric Care
HIS	<i>Historial de Salud</i> (Health Records)
ICPD	International Conference on Population and Development
INS	<i>Instituto Nacional de Salud</i> (National Health Institute)
MDG	Millennium Development Goals
MINSA	<i>Ministerio de Salud</i> (Ministry of Health)

MMR	Maternal Mortality Ratio
PAHO	Pan American Health Organisation
PHR	Physicians for Human Rights
SERUMS	<i>Servicio Rural y Urbano Marginal de Salud</i> (Rural and Urban Health Service in Marginalised Areas)
SIS	<i>Seguro Integral de Salud</i> (Integrated Health Insurance)
SDG	Sustainable Development Goals
SMI	<i>Seguro Materna e Infantil</i> (Maternal and Child Insurance)
SBA	Skilled Birth Attendant
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation

Spanish and Quechua Terms

<i>Arpillera (Sp.)</i>	Hand stitched applique panel depicting scenes of rural life
<i>Ayllu (Qu.)</i>	Community
<i>Ayni (Qu.)</i>	Reciprocity
<i>Cald(it)o (blanca) (Sp.)</i>	(White) Broth
<i>Casa (de Espera) Materna (Sp.)</i>	Maternal (Waiting) House
<i>Casa de Nacimiento (Sp.)</i>	Birthing House
<i>Chacra (Qu.)</i>	Cultivated plot of (terraced) land
<i>Chancaca (Qu.)</i>	A derivative of sugar cane
<i>Charlas (Sp.)</i>	Public Talks/Presentations
<i>Chiarinos/as (Sp.)</i>	Residents of Chiara (male and female)
<i>Choza (Qu.)</i>	Rural shephard's hut
<i>Club de Madres (Sp.)</i>	Mother's Club: a community support group organised by <i>chiarina</i> women
<i>Comadre (Sp.)</i>	“Co-Mother”, used to describe the relationship between a child's biological mother and the woman chosen to be the child's godparent.
<i>Combi (Sp.)</i>	Small mini bus serving as public transport in Chiara
<i>Comisuras (Sp.)</i>	The bones making up the skull
<i>Comunidad Campesina</i>	Rural Community

<i>Fajado (Sp.)</i>	Binding applied after birth
<i>Gestante (Sp.)</i>	Pregnant woman
<i>Historial(es) de Salud (Sp.)</i>	Medical Records
<i>Interculturalidad en Salud (Sp.)</i>	Interculturality in Health
<i>Juntos (Sp.)</i>	Cash conditionality programme operating in Chiara, meaning “Together”.
<i>Lliklla (Qu.)</i>	Brightly coloured woven blanket used to carry children or goods on a woman’s back
<i>Machismo (Sp.)</i>	Sexism
<i>Machista (Sp.)</i>	Sexist
<i>Manta</i>	Blanket
<i>Mate</i>	Herbal tea or infusión
<i>Maternidad Segura: Compromiso de Todos</i>	Maternal health campaign slogan meaning “Safe Motherhood: Everyone’s Responsibility”
<i>Mayca (Qu.)</i>	Andean herb
<i>Mamawasi (Qu.)</i>	Maternal House (see <i>Casa (de Espera) Materna</i>)
<i>Minka (Qu.)</i>	Communal Work undertaken in agricultural communities
<i>Obstetricia (Sp.)</i>	Obstetric Department
<i>Oportunidades (Sp. Mx)</i>	Mexican cash transfer programme meaning “Opportunities”
<i>Pachamama (Qu.)</i>	Mother Earth
<i>Partera (Sp.)</i>	Community Midwife

<i>Partera Profesional (Sp.)</i>	Professionally trained Midwife
<i>Parto Domiciliario</i>	Home Birth
<i>Parto Institucional (Sp.)</i>	Institutionalised Birth/Clinically Managed Birth (delivery in a state run health establishment with obstetricians present)
<i>Parto Vertical (Sp.)</i>	Vertical or Upright Birth/Delivery Technique
<i>Plan de Parto (Sp.)</i>	Delivery Plan
<i>Plan Estratégico de Salud Sexual y Reproductiva</i>	Sexual and Reproductive Health Strategy
<i>Platicas (Sp. Mx)</i>	Public talks/speeches in Mexico
<i>Pollera (Qu.)</i>	Wide pleated skirt worn by Andean women. Several may be worn on top of the other for warmth.
<i>Posta de Salud</i>	Rural health outpost (for Primary Healthcare)
<i>Qhachunis (Qu.)</i>	Daughter-in-Law
<i>Suegra (Sp.)</i>	Mother-in-Law
<i>Sobreparto</i>	“too much birth”(my translation): Andean women employ this term to describe the ill health they may experience after multiple pregnancies and births.
<i>Swiras (Qu.)</i>	Mother-in-Law

Map of Peru



Figure 1: Map of Peru by *Departamento* (Province).

Chiara is located in *Departamento de Apurímac* and Izcuchaca (Anta) in *Departamento de Cusco*.



Figure 2: *Arpillera* panels depicting the fictitious story of Mariacha, (Cuba Marín, 2012), created by Andean women in the *Cositas* Crafts Project, Cusco

Introduction: Turning Maternal Health into an Intercultural Problem

Mariacha va a ser mamá: Maria is going to be a mum

“Mariacha awoke with the smell of flowers from her dream. All night long she had had the same recurring dream: flowers of all colours, with different perfumes, different plants, fruits and fruit trees. It was the best dream that she had had of late. Her grandmother had told her once that when people dream of flowers and fruit it means that someone they know is going to have a baby.

It was 3am and Mariacha left her house clean and tidy with some food put out for her animals. She left at this time because they say that the placenta can dry out if one walks too much in the sun and because of this belief she never walked in strong sunlight. Her husband Paulino had left to work in the mine. She had to care for her children, 4-year-old Emerson and 2-year-old Julia and her big belly that was now almost 35 weeks.

Mariacha had visited the *Posta* (rural health outpost) three times and the nurses had told her that she had to come down to the *Posta* to give birth because she would be risking her health if she wanted to give birth at home. She had to cross three mountains to get there. Mariacha walked for six hours, something that would normally take her four hours at a steady pace, with Emerson and Julia left behind at home with their *comadre* (godmother),¹ Rosaura, awaiting her return. The animals were left alone at home.

Her *comadre* Rosaura stayed with Emerson and Julia. As she was walking, Mariacha grew frightened because her belly began to move from left to right and up and down in an unending dance. Mariacha sat down on a rock and rubbed her belly. At that moment she thought about who was going to be born, and if her baby would be a boy or a girl. She prayed to God just for a moment, asking that her daughter be born healthy. Her healthy daughter, yes, because she was sure that the baby was going to be a girl.

Arriving at the *Posta*, Mariacha was very tired and the walk had accelerated the baby's arrival. Her feet had swollen up. Mariacha had only wanted to be checked over and wanted to wait for Paulino before giving birth. The nurse told her that her labour had begun and her labour pains had also started. Mariacha resisted because she had to go back home for her children's sake, and for her animals that were alone and without much food. She cried with worry and this made the pain worse.

At 2am Mariacha was ready to give birth, the nurse had made her lie down and without anyone else's help, amongst her cries and the shouting of the nurse telling her to be quiet, a beautiful little girl was born.

Mariacha thought about how her daughter's arrival would have been if Paulino had been with her. He would have attended to her; he would have cut the umbilical cord with cloth so that as she grew up her clothes would last. At home, nice and warm with Paulino, she would have drunk her *caldito*, broth made with the meat of a black lamb, and she would have been able to see her children and hear her animals around her. She was sure that Paulino would have

¹ Kinship ties in the Andes place particular importance on the role of the *comadre*, (roughly translated

tied a white cloth around her head so that the *comisuras* (bones) of her skull would not open. And, she was sure that she would have given birth quickly because they had a deer hide so that the baby would come out quickly once she was crouching down.

After a few days she returned home where she was bound with cloths saturated with herbs, arnica, wine, *maycha*², eucaliptus, buddha balsalm,³ *chancaca*⁴ and urine so that all of her bones recovered their strength and knitted together again. Now fully recovered Mariacha is very happy because she has her memories of Dina's birth and Paulino is with her just as if she had given birth at home.” (Cuba Marín, 2012).

In 2012, during my fieldwork investigating Andean women's maternal health encounters, I was provided with an unexpected opportunity to delve deeper into their birth experiences, opinions and perceptions when I visited a craft workshop. Located in a marginalised district at the end of a local bus route, the workshop overlooked the ever-popular tourist city of Cusco, spread out far below as far as the eye could see. From this hilltop vantage point, inside a large adobe brick room, crammed with roughly hewn wooden tables, stools, several huge hand operated weaving looms and an assortment of coloured cloth and wools, a group of seven Andean women fashioned and sold handicrafts to earn money with which they could run their household, between breast feeding their babies and much chatter and laughter. Milagros Cuba Marín, a Peruvian anthropologist, and the workshop founder and organiser, came to greet me as I climbed the steep earth slope to the workshop entrance and we soon fell into conversation. Discovering a shared interest in anthropology, I began to talk about my thesis with her. Admiring the *arpilleras*, hand stitched hessian panels appliquéd with offcuts of coloured cloth traditionally depicting typical scenes of Andean life⁵, I enquired as to whether the women in the project could come up with a scene representing what it meant for them to become a mother

² *Maycha* refers to an Andean plant

³ 'Buddha balsam' is an ointment widely available in Peruvian pharmacies containing arnica and rosemary. It can be used for massage, to treat muscular pain, relieve symptoms of pulmonary and bronchial coughs and colds.

⁴ *Chancaca* is made of raw, unrefined sugar extract obtained from sugar cane in the initial refining process.

⁵ During the Pinochet dictatorship in Chile, women used *arpilleras* to depict the realities of life under military rule. As the *arpilleras* were considered “women's work” they escaped the scrutiny of the male-dominated regime. In this way, they provided women with a means of recording events (see Moya-Raggio, 1984; Agosin, 2008; Adams, 2013). In asking the women to stitch an *arpillera*, I hoped that they may similarly use it as a means to express their maternal health realities without drawing undue attention to themselves from health professionals or monitors within the *Juntos* programme (see Chapter 1 (Literature Review) and Chapters 3 and 4 of this thesis where I discuss the monitoring strategies in place to regulate Andean women's maternal health).

in the Andes. Milagros warmed to the idea and called the women over to discuss it with us. They were also enthusiastic and decided that rather than create one single *arpillera* they would create a series of small panels that would depict their ideas about motherhood. Not wanting to overly influence the women's ideas, I left them to let their ideas take shape and Milagros promised to call me as soon as the work was completed. A month later the eight panels were ready, which when viewed together told the fictitious story of 'Mariacha', her feelings surrounding her latest pregnancy and delivery, and the difficulties and joys she encountered and experienced throughout (Figure 2). With Milagros' assistance, the women had also narrated a storyline, which I have reproduced above, to help explain the panels and what each one represented for the women.

The story and its accompanying panels combine elements, beliefs and practices associated with home birth in the Andes with the current reality of giving birth in a Ministry of Health (MINSA) run clinic. In their own words and pictures, the Cusquenian women who collaborated on this project, create the fictitious story of Mariacha as a heuristic aid, to illustrate many of the challenges, concerns and tensions that Andean women feel underpin current maternal health policy. Mariacha's story has many threads, each revealing important considerations for maternal healthcare provision and access in the Andes, threads that I will disentangle to explore in more detail in the course of this thesis.

Mariacha's story is firstly a celebration of Andean birthing practices. Woven into the story, and illustrated in detail in the *arpillera* panels, are many of the practices that Andean women continue to associate with pregnancy, childbirth and *post partum* care. Nature, - in the form of fruits, flowers, plants and herbs - plays a key role in the story, reflecting the centrality of the *Pachamama* (Mother Earth) within the Andean cosmovision (Chávez Álvarez et al., 2007). By including details of these practices in their written and pictorial narrative, the women who collectively authored the story, highlight the continued importance of these practices in the management of their maternity. At the same time, the inclusion of these elements - all of which occur in the story outside of clinical spaces - also serve to underline the complete exclusion of such practices from clinically managed birth scenarios.

Aside from describing their own customs and traditions surrounding home birth, the women from the crafts project chose to dedicate four panels in Mariacha's story to describing the trials and tribulations she must overcome in order to access maternal healthcare via the state run public health system. Mariacha must juggle childcare and agricultural responsibilities to attend a distant health outpost for antenatal check-ups; heavily pregnant she faces geographical and logistical difficulties having to walk through the night for several hours to reach the clinic. Once there, she encounters disrespectful treatment by service providers and keenly feels the absence of family, separated due to work commitments in outlying mining districts as she gives birth alone (Cuba Marín, 2012).

In choosing to forefront such concerns, the Andean women authoring Mariacha's story reveal what they consider to be the tension points arising out of the way in which Peru's current maternal health policy is implemented on the ground. Since 2009, rural Andean women accessing maternal healthcare through the SIS (*Seguro Integral de Salud*), the Peruvian government's health insurance programme, (see Kristiansson et al. 2009; Francke, 2013; Petrera et al. 2013) must agree to give birth in a state managed clinic⁶. To encourage them to do so, the Ministry of Health has heavily promoted 'intercultural' health initiatives, which seek to incorporate many of the cultural practices associated with home birth in the Andes into clinically managed delivery (MINSA, 2009a; 2009b; Nureña, 2009; Salaverry, 2010; Knipper, 2010). However, Mariacha's story illustrates the necessity of attending to 'culture' in specific local contexts: it is not enough for the Ministry of Health to propose a 'one size fits all' solution to 'culture' (Davis-Floyd, Pigg and Cosminsky 2001:107) via an overarching Interculturality in Health initiative. Cultural initiatives must be meaningful to and effective for the women they are designed to care for. If such initiatives fail to engage their patients, the initiative will also ultimately fail (Hamilton, 2009; Walker et al., 2009). This disjuncture between how the Ministry of Health frames culture, how intercultural health in clinical spaces is promoted and provided to Andean women and how Andean women themselves understand and meet their own maternal health needs is the point of departure in my thesis. It is the 'gaps

⁶ I discuss current Ministry of Health policies surrounding maternal health in the Andes region in more detail in Chapter 1, my literature review.

in the gaze' (Gibson, 2004) where institutional priorities and policy directives collide with cultural expectations that I seek to disentangle.

In choosing 'culture' as a focal point in my thesis, I wish to reexamine the ways in which the concept has been mobilised across rural Andean populations when providing and accessing maternal healthcare in Peru. As I will detail in my literature review, many recent anthropological studies across Latin America underline the importance of improving patient-practitioner relationships to better maternal health outcomes (Chomat et al., 2014; Kvernflaten, 2013; Smith-Oka, 2013; Berry, 2013; Purnell 2012; Glei, Goldman and Rodriguez, 2003; De Vries et al. 2002; Davis-Floyd, Pigg and Cosminsky, 2001; Davis-Floyd and Sargent, 1997; Jordan, 1992 [1978]). Health initiatives that respect and recognise patients' cultural preferences and practices are credited with increasing uptake of health services amongst indigenous populations (Kayongo et al., 2006; Gabrysch et al., 2009; Hunt and Bueno de Mesquita, 2010) and specifically in terms of maternal health, affording the pregnant woman improved quality of care and lowering maternal mortality ratios (Fraser, 2008; Bristol, 2009; Callister, 2009; Zug, 2013). With their focus on the clinic as a point of care, such studies inevitably conclude that intercultural initiatives have positive outcomes within clinical spaces, for both patient and practitioner.

However, in focusing solely on patients' responses to intercultural initiatives, studies carried out within clinical spaces (see Kayongo et al., 2006; Fraser, 2008; Bristol, 2009; Callister, 2009; Gabrysch et. al., 2009; Hunt and Bueno de Mesquita, 2010; Zug, 2013) overlook the perspectives of those Andean women who are not patients within the state run public health system. These women remain beyond the reach of intercultural care initiatives; whether through personal choice, having chosen to forego the public health system or because they are uninsured - and thus unregistered, they are also 'invisible' to Ministry of Health run establishments. It is the opinions and maternal health experiences of these women, the ways in which the Ministry of Health and the state seek to incorporate them into the system and the attitudes and reactions of health professionals towards them that I also seek to uncover in this thesis and which, in so doing, necessarily prompts a reassessment of 'culture', and how it is understood and harnessed to achieve specific outcomes in maternal health provision in the Peruvian Andes. Further, in opting to carry out my research in rural locations, I

hope to shed light on the difficulties alluded to in Mariacha's story which face impoverished rural women as they struggle to access maternal healthcare as it is currently provided via the SIS insurance programme. For rural women, maternal health does not just happen in the clinic, it occurs in the homes and work spaces, terraces and fields, market places and communal meeting halls that make up their everyday lives. What happens on their way to the clinic, the health trajectories and pathways to care before their antenatal consultation or delivery takes place, the conversations they have with family, friends, neighbours and health professionals – all influence and inform the maternal health decisions that Andean women make. Thus, my thesis does not focus exclusively on the health encounters that take place in clinical spaces, but widens the scope of the study to include health encounters occurring (or failing to occur) outside of the clinic, for both insured and uninsured rural women.

In order to situate the reader, in what follows, I will first provide an overview of the scope of global maternal mortality, before discussing maternal mortality in Peru. I then provide a brief historical account of the troubled reproductive health trajectory in the Andes region, upon which current maternal health policy is superimposed. I end describing how the Ministry of Health currently frames 'culture' in its health discourse, and I discuss why, in light of such framing, intercultural health initiatives are problematic. This leads me to the literature review, which grounds this thesis.

Maternal Mortality: A Global Concern

Maternal mortality – the death of women during pregnancy, childbirth or the 42 days after delivery (Hogan et al., 2010) – represents a continued major challenge to public health systems throughout the world, despite significant reductions in the maternal mortality ratio (MMR) across the globe. Whilst statistics published in 2017, show a decline of 44% in global MMR between 1990 and 2015, from 385 deaths to 216 deaths per 100,000 live births (UNICEF, 2017), this represents an average annual rate of reduction in MMR of 2.3%, less than half the 5.5% annual rate needed to achieve the three-quarters reduction in MMR targeted in the Millennium Development Goal 5 (UNICEF, 2017). Whilst every continental region has made progress in reducing

MMR, huge disparities remain between the global north and the global south (Figure 3 below).

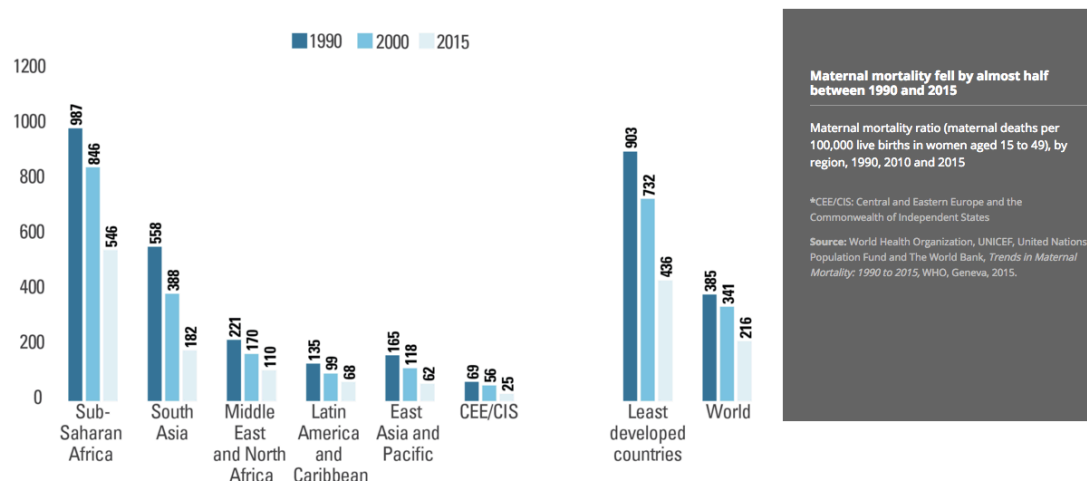


Figure 3: Distribution of Global MMR by region, 1990-2015.
Source: WHO, 2015.

The number of women and girls dying from complications in pregnancy and childbirth has declined from 532,000 in 1990 to 303,000 in 2015, nevertheless 800 women continue to die each day from complications during pregnancy and birth (UNICEF, 2017). For every woman that dies, a further 20 will suffer serious injuries, infections or disabilities (UNICEF, 2017). Almost all maternal deaths (99%) occur in developing regions (UNICEF, 2017), with Sub-Saharan Africa and South East Asia continuing to record the highest MMR (Figure 3).

Across Latin America and the Caribbean (LAC), MMR declined by an average of 40% between 1990 and 2013 across 11 countries (PAHO/WHO, 2014)⁷. However, this figure was less than the global average and fell significantly short of the 75% required to meet MDG5 in 2015. In 2013, an estimated 9,300 women lost their lives

⁷ The 11 countries are Barbados (-56%), Bolivia (-61%), Brazil (-43%), the Dominican Republic (-57%), Ecuador (-44%), El Salvador (-39%), Guatemala (-49%), Haiti (-43%), Honduras (-60%), Nicaragua (-38%), and Peru (-64%). All of these countries started with relatively high MMR (>100 per 100,000) (PAHO/WHO, 2014).

due to pregnancy related causes across LAC (PAHO/WHO, 2014). Whilst progress in achieving the MDGs at a regional and national level was shown across LAC (PAHO/WHO, 2014), preventable maternal and neonatal mortality still persists (UNICEF, 2014).

In 2016, the MDGs were renamed the Sustainable Development Goals (SDGs), reflecting signatories' continued commitment to achieving and maintaining each of the goals. In order to achieve the global target of less than 70 maternal deaths per 100,000 live births by 2030 requires a global annual rate of reduction of at least 7.5 per cent, more than double the rate achieved between 2000 and 2015 (UNICEF, 2017). Yet, providing antenatal care during pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth can prevent most maternal deaths (UNICEF, 2017).

MMR in Peru

The maternal mortality ratio in Peru has declined nationally by 64% between 1990 and 2013 (PAHO/WHO, 2017). Nevertheless, huge regional disparities in MMR exist across Peru, with MINSA estimating the maternal death rate in rural areas to be 161.5 deaths per 100,000 live births between 2007-2011, with the highest figures recorded in the Sierra and the Selva regions (del Carpio Ancaya, 2013: Figure 4).

	2002-2006	2007-2011
Región		
Costa	59,5	56,4
Sierra	138,7	152,6
Selva	183,0	137,5
Zona		
Urbana	76,9	70,0
Rural	192,1	161,5
Quintil de pobreza		
I	241,7	188,7
II	299,2	169,3
III	284,6	145,5
IV	154,2	104,0
V	17,6	58,5

Figure 4: Maternal Mortality in Peru according to region (Coast, Sierra, Jungle), area (urban, rural) and poverty quintile 2002-2011 (MINSA, 2013, cited in del Carpio Ancaya, 2013: 462).

There has been a significant reduction in MMR across rural areas since 2006 (192.1 per 100,000 live births between 2002-2006), and yet in the Sierra, maternal mortality has risen from 138.7 between 2002 -2006 to 152.6 per 100.000 live births between 2007-2011. In 2011 the Andes region was therefore bucking the national and global trend with MMR rising rather than falling.

It is in investigating the reasons why the Andes region continued to see a rise in MMR and the particular ways in which the Ministry of Health attempted to tackle this disparity through specific policy measures, promotional campaigns and targeted research that my literature review begins. However, before doing so, it is important to trace the trajectory of reproductive health in the Andes region, to provide the background and context upon which this thesis is written.

History of Reproductive Health in the Andes

Until the early 1990s, the Peruvian government gave scant consideration to population issues and its family planning programmes were poorly organised and relatively ineffective (Aramburu, 1994; Reyes and Ochoa, 1997; Mannarelli, 1997). Insufficient funding and political support hampered reproductive health initiatives, compounded by the Peruvian economic collapse and ensuing political crisis

characterising the Eighties, factors that saw out Alan Garcia's presidential term in 1990 (Reyes and Ochoa, 1997; Mannarelli, 1997). After the 1994 International Conference on Population and Development, the Peruvian government began to make steps towards fulfilling reproductive health rights and objectives (Mannarelli, 1997; Murillo Hernandez, 2000; Dador et al., 2001). However, progress was overshadowed by two periods of reproductive health history which have shaped Andean women's perceptions of reproductive health policy in Peru and which continue to cause unresolved controversies today (Getgen Kestenbaum, 2008; Pieper Mooney, 2010; Pegram, 2011). The first, between 1996-1997, was demographic in nature, and the second between 2001-2003 emanated from far right politics (Tamayo, 1999; Villanueva, 1998; Chavez and Cisneros, 2004).

The modernizing reforms of Alberto Fujimori from 1993-1998, specifically tied reproductive health to neoliberal development plans for the first time in a "modernization" of the health sector (Cáceres, Cueto and Palomino, 2008). His objective was to advance the economic development of the country by bringing the growing population under control. Consequently, in a predominantly Catholic country, where reproductive and sexual health issues are considered highly sensitive (ibid) and where health issues had previously not formed part of the government agenda (Gonzales, Rojas and Villa, 2000) Fujimori placed family planning at the forefront of government health priorities with the introduction of family planning reform. Initially, Fujimori's reforms were lauded: a demographic survey of 1991-1992 had demonstrated a widespread desire amongst Peruvians to have fewer children and control their fertility, yet large sectors of the population lacked the means to fulfil this desire (Padilla and Ochoa, 1992). Furthermore, women's rights advocates had begun to pressure policy makers to recognise that gender inequalities work against women's reproductive health. In addition, with the economic and political situation stabilised, the government had more leverage to argue against the Catholic hierarchy and foreign donors invested heavily in family planning and maternal health initiatives (Coe, 2004). At the Beijing conference in 1995, Fujimori openly promoted women's universal access to contraceptives. Official government discourse placed this issue within the context of social justice and reproductive rights: poor women deserved the same opportunity as wealthier women to regulate their fertility, and all women had

the right to control their bodies and use contraceptives if they wished (Coe, 2004; Parker, 1995).

By 1996, Fujimori's first term in government had failed to secure a reduction in poverty or an increase in employment despite the implementation of neo-liberal policies (Mannarelli, 1997). The government responded by making contraceptive services the core component of its mass poverty relief programme (Mannarelli, 1997; Murillo Hernández, 1997). The fertility of poor women was targeted, with the Ministry of Health announcing:

“The fertility rate among poor women is 6.9 children – they are poor and are producing more poor people. The president is aware that the government cannot fight poverty without reducing poor people's fertility. Thus, demographic goals are a combination of the population's right to access family planning and the government's anti-poverty strategy.” (Programme manager, Ministry of Health, Lima 1998, quoted in Coe, 2004: 61-62).

The policy increased the use of modern contraceptives, especially sterilisation, largely among poor, disenfranchised women with little or no formal education (Tamayo, 1999; Villanueva, 1998). By linking family planning to a broader governmental policy of poverty reduction, the reformed family planning policy covertly favoured population control over reproductive rights (Cáceres et al., 2010; Ewig 2010a; 2010b). The reproductive rights and the control of *specific* populations thus became the subject of the reforms. Many of the 250,000 sterilizations (Bosch, 2002) carried out under the new policy were performed without the correct informed consent procedure being followed (Miranda and Yamin, 2004), with many indigenous, rural women being cajoled or deceived into the procedure according to women's rights activists and NGOs (Ewig, 2010b). Sterilisation programmes were scaled up in rural areas, with inadequately prepared surgical teams being dispatched to rural and isolated Andean areas, other forms of contraception being withheld, blatant deception, economic incentives and threats being used by health professionals, under increasing pressure to meet sterilisation targets (Tamayo, 1998; Villanueva, 2000; Coe, 2004). In 1998 and 1999, it was revealed by the national press that many sterilisations had been carried out involuntarily (Cáceres, Cueto and Palomino, 2008; Zauzich 2000), the majority having been performed on rural, poor, indigenous women (Villanueva, 2000).

When the enforced sterilisations came to light in 1998, the Catholic Church, far right advocacy groups and ultra-right politicians used the news to garner support for their own agenda, calling for an immediate end to government sponsored family planning programmes. In 2001, the country's first indigenous president, Alejandro Toledo took office and appointed several ultra-right politicians to top cabinet posts, including the Ministry of Health (MINSA). The far-right health model subsequently emanating from MINSA sought to subordinate women, promoting motherhood as women's only role, to be preserved at all costs (Chavez and Cisneros, 2004). Family planning and sexual education was removed from health policy, impeding information and access to modern contraception methods and dis-information campaigns began discrediting condom use as ineffective against sexually transmitted infections (STIs) and HIV. Health centres were also found to block women's access to contraceptives (Villanueva et al., 2002) and STIs/HIV prevention programmes were eradicated. Information about gynaecological cancer was also withheld and treating complications arising from unsafe abortion were prohibited across health centres (Coe, 2004).

The turbulent reproductive health history outlined above still has repercussions for Andean women today. The enforced sterilisation campaigns of the Nineties are an unresolved issue in Peru, with women's rights activists still campaigning in 2017 for reproductive and social justice (flora.org, 2017; Gutierrez, 2014). The contraceptive misinformation campaigns and the barriers impeding women's access to contraception, treatment for STIs and HIV have further bolstered mistrust amongst Andean women attending state run health establishments for sexual and reproductive health advice and treatment. Whilst it can be argued that such scenarios are rooted in the historical past, such abuses are still within living memory for many women, who are now grandmothers (or not). This has important implications for my study, as an ethnographic perspective necessarily seeks to situate its findings within socio-cultural, historical and political economic context. I have thus included an account of past reproductive health trajectories here, as given the centrality of the family and the influence that older female relatives exert over their younger counterparts (issues that I discuss in Chapter 5), I suggest that these women's experiences are still relevant in

2017⁸. Therefore, when examining maternal health as it is practiced in the Andes today, it is crucial to situate current events and Andean women's understandings of policy within the historic political past into which they are embedded.

Maternal health as a cultural 'problem'⁹

Just as Andean women's fertility had been specifically targeted in the Nineties as I have discussed above, they have again become the focus of targeted reproductive interventions much more recently. Under the auspices of the *Plan Estratégico Nacional para la reducción de la Mortalidad Materna y Perinatal 2009 – 2015* (National Strategy for the Reduction of Maternal and Neonatal Death 2009-2015, MINSA, 2009), and its later modifications post 2015, the Ministry of Health, as one of the signatories of the Millennium Development Goals (MDG), began to promote *parto institucional* (clinically managed birth) across Andean regions, in order to attempt to reduce maternal mortality in the region. One of the ways that MINSA attempts to attract Andean women to the clinic to give birth is through the incorporation of 'intercultural' initiatives into their encounters with patients, as I have detailed previously in this introduction. The initiative not only aims to introduce specific cultural elements associated with home birth in the Andes into clinical spaces, but also aims to educate health professionals to recognise and respect cultural differences¹⁰ in their consultations with patients. In so doing, the current strategy positions culture as a determinant of maternal health, a 'barrier' to be overcome in the provision of healthcare in the Andes¹¹. An excerpt from a training manual for health professionals attending to indigenous women in state run clinics explains:

"Cultural Barriers

A series of cultural factors exist that limit access to health services. These are related to particular customs that determine the attention given to the mother and the new-born in the communities, the same customs that have been passed down from one generation to the next". (MINSA, 2010:30: my translation).

⁸ The debate around the enforced sterilization of indigenous Andean women remains unresolved and continues to generate discussion, division and political controversy in Peru today (Getgen Kestenbaum, 2008; Pieper Mooney, 2010; Pegram, 2011).

⁹ I have placed 'problem' in inverted commas here to denote my position that I see the cultural emphasis placed on maternal health challenges not as a problem in their own right, but rather a socially constructed one.

¹⁰ I discuss recent MINSA strategies pertaining to clinically managed birth and intercultural healthcare in more detail in Chapter 1, my literature review.

¹¹ I discuss this point in more detail in Chapter 1, my literature review.

The manual goes on to list a series of ‘cultural’ impediments identified in a qualitative study carried out by MINSA across health establishments in the Andean city of Ayacucho in Huamanga Province (Figure 5).

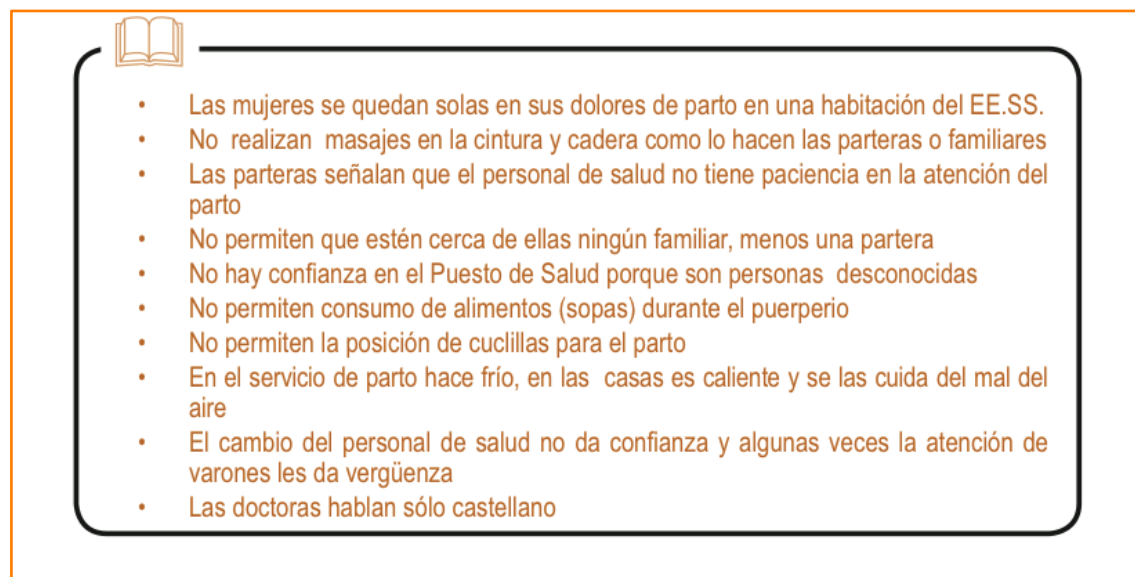


Figure 5: List of ‘cultural’ factors identified by MINSA, which impede indigenous women attending health establishments to give birth. Source: MINSA, 2010a:30.

My translation is given below.

- Women are left alone in a room during labour in health establishments
- Massages to the waist or hip are not carried out as they would be with a midwife or family member
- Midwives ascertain that health providers lack patience when attending births
- Health professionals do not allow family members to accompany the woman in labour, and midwives less so
- There is a lack of confidence in the staff at the health outpost as they are unknown people
- Food is not allowed to be consumed (soup) during the postnatal period
- Crouching to give birth is disallowed
- It is cold when giving birth in clinics whilst at home it is warm and women are protected from *mal de aire* (illness arising from exposure to extremes of hot or cold air).
- Changes in health personnel do not engender confidence and at times attendance by a male practitioner causes embarrassment
- Doctors only speak Spanish

Such renderings of culture, which position it as an obstacle to health, stand at odds with Andean women's understandings of their own maternal health practices. During the course of my fieldwork, in attempting to unravel the complexities of the 'cultural' argument, I would often begin by asking health professionals if they felt that 'culture' was an impediment to maternal health. Invariably, their answers would affirm the viewpoints put forth in the Ministry of Health documents and in published public health research: it is important to respect and recognise cultural differences (MINSA, 2010a); Andean women held different ideas about pregnancy and birth emanating from their 'culture' (ibid); it is a challenge for practitioners to successfully incorporate intercultural healthcare into their work due to language barriers or lack of training (ibid). When I asked Andean women the same question, the 'cultural' was framed very differently. Whilst they recognised that challenges do exist for them to access state run healthcare, these had more to do with issues surrounding quality of care, linguistic difficulties or geographical distance from the clinic. The Ministry of Health views their practices and traditions around pregnancy and birth as a difficulty or particular cultural challenge to be overcome, but Andean women view their practices as a celebration of the creation of new life. Where such cultural practices could be incorporated into state run healthcare, their inclusion could only enrich their experience.

My thesis begins at this disjuncture between Andean women's understandings of culture as an enriching experience and the Ministry of Health's framing of it as a barrier to maternal health provision. In Chapter 1, my literature review, I examine how maternal health is presented and understood in Latin America and Peru across the epidemiological, health and social policy, qualitative health research and ethnographic literatures. I begin with an examination of the breadth and scope of MMR in Peru, and examine how the Ministry of Health has responded to findings about the Peru's maternal mortality problem emerging from the epidemiological literature.

Chapter One: Literature Review: Maternal Health and Maternal Mortality in Peru

Introduction

This chapter describes and critically appraises the published literature around maternal health and maternal mortality in Peru, drawing particular attention to how maternal health is prioritised, delivered to and accessed by rural women in the Peruvian Andes. The maternal mortality ratio (MMR) in Peru currently stands at 68 per 100,000 live births (WHO et al., 2015)¹² and improving access to maternal health services is the fourth most important public health priority in the country for the state, government research bodies and the Ministry of Health (Caballero et al., 2010). Consequently, maternal health and MMR in Peru has been examined across a range of disciplinary perspectives drawn from the social sciences and public health literatures, which focus on a shared concern for understanding how maternal health service provision and access is currently delivered to Peruvian women, and how this may be improved to lower the maternal mortality ratio. This chapter will examine published research drawn from the epidemiological and health and social policy literatures pertaining to maternal health and maternal mortality in Peru. In addition, I examine qualitative health research and ethnographic literature, drawing broadly upon anthropological and sociological research that seeks to investigate maternal health within its socio-cultural context. The chapter is therefore organised into four sections.

In part one, in reviewing the epidemiological research pertinent to maternal health in Peru, I describe the extent of the maternal mortality problem: drawing attention to the prevalence of maternal mortality in Andean regions and populations. Peruvian epidemiologists show us that maternal health outcomes and MMR are closely bound up with structural inequalities such as socio-economic status and educational level, in addition to inequalities of access due to geographic location. Further, their work highlights that structural inequalities are also an outcome of the organisation of the public health system in Peru: births and deaths take place in a fragmented, inequitable

¹² World Bank estimates place MMR in Peru at 251 per 100,000 live births in 1990. The country has therefore seen a substantial drop in MMR. Peru nevertheless failed to meet its MDG 2015 target of 66.3 deaths per 100,000 live births (World Bank, 2015). See <http://data.worldbank.org/indicator/SH.STA.MMRT>. Accessed 4th December 2016.

and overburdened health system, where health insurance programmes fail to reach impoverished populations and shortages of health personnel exacerbate the problem.

Building on this analysis in part two, I introduce key policy initiatives relevant to current maternal health in Peru, drawing on the work of Peruvian sociologists and public health scholars who have conducted studies of the Peruvian public health system. This policy focussed literature enables us to see how understandings of MMR emerging from the epidemiological literature have been translated into policy measures designed to reduce maternal mortality. I focus specifically on the Sexual and Reproductive Health Strategy 2009-2015, describing and critically appraising the initiatives that make up the strategy. In so doing, I discuss how particular initiatives have come to be implemented in Andean regions of Peru, to improve access to institutionalised childbirth and the provision of emergency obstetric care for indigenous populations and communities. In addition, I show how ideas and understandings of culture and ethnicity have thus come to be highlighted as central concerns for current maternal health policy, impacting upon the maternal health options available to Andean women.

In part three, I turn to qualitative health research from nursing and sociology disciplines to draw out the individual experiences of both the Andean women accessing maternal healthcare as patients, and the practitioners charged with providing this care to them. This qualitative health literature provides valuable insights into how generalised policy initiatives responding to and emanating from epidemiological descriptions of the prevalence and causes of maternal mortality, become influenced by individual perceptions, and are subsequently implemented, practiced and negotiated in local realities in particular ways. The qualitative health literature reviewed thus pinpoints the importance of local context and individual experience and illustrates that Andean women's understandings of maternal health greatly influence how they make decisions regarding their sexual and reproductive health.

In the fourth and final part of this chapter, I review Latin American ethnographic research from the fields of anthropology and sociology, which examine the socio-cultural contexts and political economies into which maternal health is embedded, in what has been termed an "Anthropology of Reproduction" (Jordan, 1978). These

studies recognise that maternal health and MMR, including the way in which it is problematised across the epidemiological and social science literatures, cannot exist within a vacuum, but rather, is shaped by the myriad societal, political and economic factors that influence health outcomes (Biehl and Petryna, 2013). I argue that an ethnographic perspective shines ‘an empirical lantern’ (Hirschmann, 1988, in Biehl and Petryna, 2013), helping us examine maternal health beyond the epidemiological domain and acknowledging the entanglements between the social, cultural, political and biological dimensions of maternal health provision and outcomes in Peru. Thus, across the four sections, this chapter provides the reader with an introduction to the scale of the problem of MMR in Peru; the unequal way that problem is distributed across the population; the structural bases of those inequalities; how the MMR problem and maternal health is understood and negotiated in context; and the implications for the lives of, in particular, impoverished rural women giving birth in the Andes.

Epidemiological contributions to understandings of maternal health and MMR in Peru

Maternal mortality – defined by the World Health Organisation (WHO) as the death of women during pregnancy, childbirth or the 42 days after delivery (Khan et al. 2006; Hogan et al., 2010) – represents a major challenge for public health throughout the world. Half a million women die as a result of childbirth each year around the globe (UNICEF, 2008), despite 88-99% of maternal deaths being preventable (Campbell and Graham, 2006). An additional ten million women suffer childbirth related injuries or illness annually (UNICEF, 2008) and 99% of all maternal deaths occur in the global south (WHO, 2015), with most women in developing countries giving birth at home rather than in a health facility (Bustreo, Harding and Axelsson, 2003). In line with the trend in the global south, Peru is a country which is described by epidemiologists as having a high maternal and child mortality burden. In 1996, the country’s MMR was recorded at 265 deaths per 100, 000 live births, reducing to 185 deaths in 2000 and 93 in 2011 (WHO, 2015). In 2012, Peru was one of 10 countries¹³

¹³ The other countries were Bangladesh, Cambodia, China, Egypt, Ethiopia, the Lao People’s Democratic Republic, Nepal, Rwanda and Viet Nam (PMNCH, 2014).

designated as being on the fast-track to meet the Millennium Development Goals¹⁴ target for a 75% reduction in maternal mortality (WHO, 2015:4). Yet, despite making significant progress in the reduction of MMR since the 1990s, Peru nevertheless failed to meet its MDG 2015 target of 66.3 deaths per 100, 000 live births (WHO, 2015).

As a result, and like many countries in the global south, maternal death in Peru remains one of the leading causes of mortality in the 21st century (WHO, 2015), a consequence of both direct and indirect causes. In Peru, in 2015, the Ministry of Health (MINSA) attributed the leading direct cause of maternal death to haemorrhage (36.5%, n=66) followed by pregnancy induced hypertension (31.5%, n=57), sepsis (21.5%, n=39), and other pregnancy related infections (10.5%, n=19) (MINSA 2016)¹⁵. Indirect obstetric causes of MMR in Peru were attributed by MINSA to infection (24.4%, n=22), self inflicted injury, violence or mental health problems (14.4%, n=13), cerebral or vascular illness and other nervous system illnesses (13.3%, n=12), Cardiovascular disease (12.2%, n=11), tumours (7.8%, n=7), endocrinological disease (5.6%, n=5), digestive system disorders (4.4%, n=4) and other indirect causes (17.8%, n=16) (MINSA, 2016a).

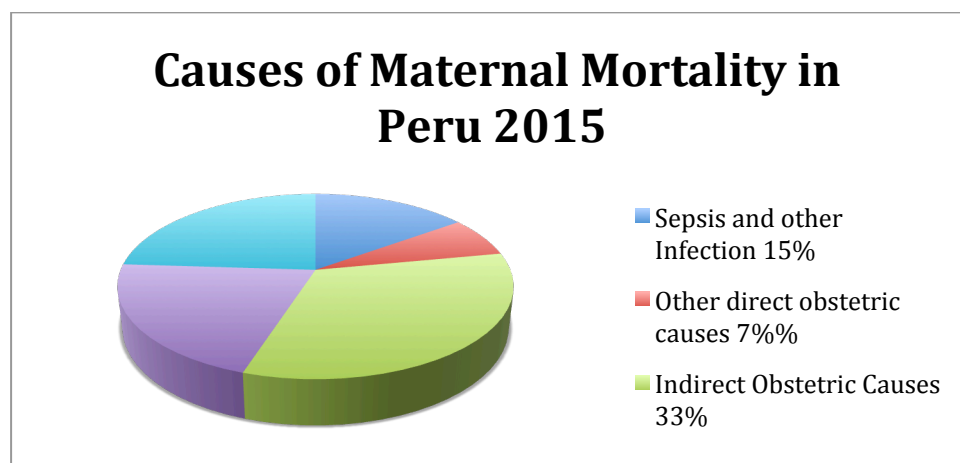


Figure 6: Causes of Maternal Mortality in Peru 2015

Source: Sistema Nacional de Vigilancia Epidemiológico en Salud Pública – DGE-MINSA. (MINSA, 2016).

¹⁴ MDG 4 concerns the reduction of child mortality, MDG 5a, the reduction of maternal mortality and MDG 5b, universal access to maternal healthcare.

¹⁵ The Ministry of Health (MINSA) uses its own data monitoring systems provided monthly by DIRESA – the regional health authorities - to determine epidemiological indicators of MMR. I discuss this data monitoring in more detail in subsequent chapters of this thesis.

Peru is characterised as having a long history of high MMR, although prior to 1987 maternal health programmes in developing countries paid scant attention to the factors causing women to die, focusing instead on neonatal mortality (Rosenfield and Maine, 1985; Starrs, 2006). WHO's announcement at the end of the UN Decade for Women that half a million women were dying every year from obstetric complications (WHO, 1985) positioned MMR as a key public health concern, prompting action. Like other countries in the global south, Peru participated in the Nairobi Safe Motherhood Conference in 1987 (World Bank, 1992). The resulting Safe Motherhood Initiative led to epidemiologists and policy researchers publishing a wide body of literature calling for improvements in access to emergency obstetric services, midwifery training and quality of care to reduce the burden of MMR across the global south (Herz et al., 1987; Kwast, 1991; Kwast and Bentley, 1991; Graham and Campbell, 1992; Maclean and Tickner, 1992; Maine, McCarthy and Ward, 1992; Koblinsky, 1995; Kwast, 1998a; Kwast, 1998b; Koblinsky, Campbell and Heichelheim, 1999; Maine, 1999; Barros et al., 2001; Maclean, 2003; Houweling et al., 2007). By 1994 and the International Conference on Population and Development, safe motherhood was firmly ensconced as a core component of reproductive health (IPCDPA, 1994). The importance of maternal survival was reinforced in 2000, with the development of the Millennium Development Goals. MDG 5a aimed for a 75% reduction of MMR globally by 2015; in 2007 MDG 5b was added, incorporating universal access to maternal health services for all populations (Shaw and Cook, 2012).

Reflecting the growing concern about the incidence and prevalence of MMR globally, and its status as a signatory to the Millennium Development Goals, Peru embarked upon an expansion of maternal health programmes and the development of coordinated strategies to combat the continued high incidence of MMR nationally. Epidemiologists sought to convince the Ministry of Health (MINSA), the national authority on health, of the importance of maternal health provision as a national public health concern, arguing that greater effort had to be made to tackle the growing incidence (Ticona and Huanco, 2003; Ticona and Huanco, 2005; Pacheco, 2006; Arrieta-Herrera and Riesco de la Vega, 2009; Alcalde-Rabanal, Lazo-Gonzalez and Nigenda, 2011; del Carpio Ancaya, 2013; Farro and Romero, 2015; Sánchez, 2015). The need to explain the scale, scope, and costs of the problem, coupled with the challenge from international health agencies to reduce MMR, provided the impetus

for epidemiologists and public health researchers to join forces and undertake research that would subsequently guide and inform maternal health policy. The Peruvian literature provides insights into how understandings of this problem were gradually broadened through the publication of data – generally statistical – that showed the prevalence and incidence of MMR in Peru to be a very specific regional, rather than national problem, one occurring particularly amongst indigenous rural populations in both the Andes and Amazonian regions.

Repeatedly identified by the *Instituto Nacional de Salud* (INS: National Health Institute)¹⁶ as a research priority, early INS lead research presented the incidence and prevalence of MMR as being a problem directly linked to inequitable access to maternal health provision, due in particular, to economic inequalities amongst Peru's poorest populations (Alcala and de la Galvez-Murillo, 1994; Chirinos, Sobrevilla and Alcantara, 1994; Becerra et al., 1998; Pacheco, Farro and Elias, 1999; Jaramillo and Parodi, 2004). The ineffectiveness of the *Seguro Materna e Infantil* (SMI: Maternal and Child Health Insurance)¹⁷ in improving equitable access to maternal health services (Jaramillo and Parodi, 2004) was also considered an on-going concern for the State, leading to the new *Seguro Integral de Salud* (SIS: Integrated Health Insurance) being introduced in 2001, increasing coverage amongst Peru's poorest populations. (See Valdivia, (2002); Kristiansson et al. (2009); Petrera et al. (2013) and Francke (2013) for an overview).

Subsequent attempts at estimating the prevalence and incidence of MMR in Peru continued to frame MMR as a consequence of economic inequalities coupled with inequitable access to maternal health services (Alcalde-Rabanal, Lazo-Gonzalez and Nigenda, 2011; Reyes Armas and Villar, 2012; del Carpio Ancaya, 2013). As such, Peruvian research continued to focus principally upon the pressing need for the government to expand its maternal health insurance programmes, with particular concern increasingly given to how to improve access to institutionalised birth for the country's poorest populations (Parodi, 2005; Morales Alvarado 2009, Timana and

¹⁶ The Peruvian National Health Institute (INS) is the research arm of the Ministry of Health (MINSA). INS produced research has been responsible in large part for the publicising of the maternal mortality problem in Peru, informing and influencing national debate as well as influencing international players such as NGOs active in the maternal health arena. The influence of the INS has thus inevitably shaped past and current maternal health policy (Caballero et al., 2010).

Margaret, 2015). Significantly, research by Sandro Parodi (2005), went further, identifying several non-economic factors impacting on maternal health access that he suggested were not adequately considered in the drawing up of the new SIS insurance programme. These factors were geography, ethnicity, cultural practices and power relationships within the home (Parodi, 2005:0). Parodi's study drew on demographic data¹⁸ to firmly position MMR as a socio-cultural and economic problem, concluding that restricted access to maternal health provision is a particular problem occurring amongst specific population groups. For Parodi, the pregnant women

“...Who speak a native language, who live in rural areas and/or those whose husbands have the last word in health decisions have the least likelihood of asking for an institutionalised birth, even after they have attended ante natal check ups, due to a series of characteristics both personal and familial”. (Parodi, 2005:0).

Parodi's study concludes by recommending that the Peruvian health authorities take into greater consideration the geographical and cultural complexities compounding the epidemiology of maternal health in Peru (Parodi, 2005:35).

Thus we learn from these studies that Peruvian researchers present maternal health and MMR as a problem of access to services for women of low socio-economic status, living in remote geographical areas of the country (Alcala and de la Galvez-Murillo, 1994; Chirinos, Sobrevilla and Alcantara, 1994; Becerra et al., 1998; Alcalde-Rabanal, Lazo-Gonzalez and Nigenda, 2011). In addition, following Parodi (2005), a more nuanced interpretation of MMR becomes visible: ethnicity and language, cultural practices, and familial characteristics are also presented as factors to explain high MMR amongst particular population groups.

Further research, building upon the recommendations put forward by Parodi, also began to forefront ethnicity, gender inequality within the home and low educational level as factors contributing to high MMR (Benavides, 2005). MINSA emphasised the disparity between MMR in rural and urban areas of Peru in particular (Anderson,

¹⁷ The SMI was the first maternal health insurance programme to be trialed in Peru. It provided coverage for pregnancy related illness and associated health risks; antenatal care; obstetric care for natural birth or caesarean; post-natal care; nutritional supplements and dental care.

¹⁸ The study took demographic data from the *Encuesta Demográfica y de Salud Familiar* (ENDES) 2004, the Peruvian Demographic and Family Health Survey.

1999; Gonzalez et al., 2006; Gonzalez, 2012; Velasquez-Hurtado et al. 2014) publishing statistics in 2010 comparing the number of clinically managed births across rural and urban areas (Figure 7). Thus by 2010, MINSA clearly delineated MMR as a problem pertinent to rural women with a low educational level and whose first language was a native language other than Spanish (Figure 7).

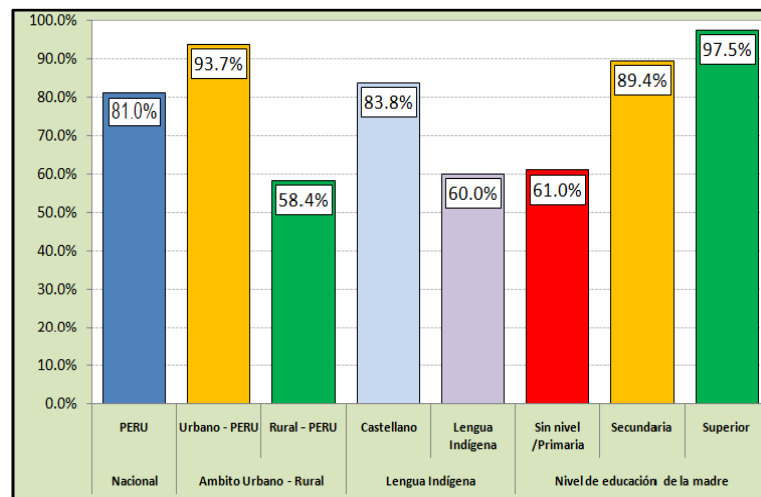


Figure 7: Parto Institucional (clinically managed birth) in Peru 2010. Source: MINSA/ENDES, 2010.

The graph shows percentage rates for clinically managed birth across national and urban/rural divides; language spoken (Spanish/Indigenous); and educational level (No education/primary, Secondary and Higher).

The urban-rural health inequities identified as a key concern by epidemiologists (Alcala and de la Galvez-Murillo, 1994; Chirinos, Sobrevilla and Alcantara, 1994; Becerra et al., 1998; Alcalde-Rabanal, Lazo-Gonzalez and Nigenda, 2011) have led policy makers to focus their attention on a new decentralised public health strategy, previous centralised approaches being critiqued for contributing to a scarcity in health resources nationally with gaps in equity affecting the poorest rural populations in particular (Caballero et al., 2010). The new decentralised strategy clearly identified maternal health as a continued health priority: positioning the reduction of MMR the

fourth most pressing public health concern nationally (Caballero et al., 2010)¹⁹. Across the global south global initiatives such as the MDG also called for increased efforts from signatories to reduce their maternal mortality ratios and widen health coverage for all (Barros et al., 2010; Bhutta et al., 2010; Culwell et al., 2010; Hogan et al. 2010; Horton, 2010; Ki-Moon, 2010; UNICEF, 2010).

As a result, in cities and urban areas the impact and cost effectiveness of obstetric interventions in reducing MMR was to be evaluated (Diaz Hajar, 2011; Tavara et al., 2011; Valencia-Mendoza et al., 2011; Carmona, 2016), whilst in areas with a high percentage of impoverished, rural and indigenous populations (such as Amazonas and the Andean regions), the focus was to investigate what the INS referred to as the ‘cultural determinants’²⁰ (see Caballero et al. 2010:404) contributing to high MMR and low uptake of maternal health services (see also Rivas, 2010; Salaverry, 2010; Valenzuela-Ore et al., 2015) in addition to the effectiveness of government sponsored development programmes designed to increase access to institutionalised birth (see Hidalgo, 2008; Perova and Vakis, 2009b, 2011, 2012; Diaz et al. 2009; Aramburu, 2010; Arroyo, 2010; Trivelli and Diaz, 2010; Segovia, 2011; Vargas, 2011; Escobal and Benites, 2012). Thus, the INS research agenda, in the setting of very specific regional research priorities, further underlined inequalities of access between urban and rural populations. It also framed incidence of high MMR as directly related to cultural practices, poverty and development issues. Culture in particular was presented as a determinant of health outcome, a potential barrier to maternal health access and a contributing factor to maternal mortality in rural areas with a high percentage of indigenous populations.

The underlying message emerging from the epidemiological literature on MMR and maternal health in Peru is that a number of major challenges face the Peruvian health system. Foremost is the necessary extension of health insurance coverage to include impoverished populations without the financial means to access primary health services (Arce, 2009; Ugarte Ubilluz 2009; Wilson, Velasquez and Ponce, 2009;

¹⁹ Public Health Priorities identified at the forum were in order of importance: Human Resources in Health; Mental Health; Child Malnutrition; Maternal Mortality; Transmittable Diseases (Caballero et al., 2010; 407).

²⁰ The INS positions culture as being a determinant of health whereby cultural norms thus define health-seeking practices. In this thesis, following Michael Agar (2006), I position culture as a translation mechanism, to allow us to better understand health practices. Culture is thus a changing, fluid concept, rather than static and tangible. See Agar (2006).

Alcalde-Rabanal, Lazo-Gonzalez and Nigenda, 2011). Secondly, whilst coverage is improving (del Carpio Ancaya, 2013), the health services are unable to respond promptly in regional areas due to human resource shortages that fail to meet demographic change and an increased commitment to universal health coverage (Caballero et al. 2010; Bustos et al., 2015). Thirdly, maternal mortality is a problem particularly affecting impoverished, rural women living in remote geographical areas where access to health services is difficult and may be compounded by cultural factors (Nureña, 2009; Ugarte Ubilluz, 2009; Knipper, 2010; Salaverry, 2010).

Epidemiologists thus understand that the joint problems of maternal health provision and MMR extend beyond the medical domain, reaching into wider structural causes. An examination of the health and social policy literature reveals how the causal processes and explanations emerging from the epidemiological literature on MMR are translated into specific policy measures designed to reduce its incidence and how such policies are implemented *in situ*. In the subsequent part of this chapter then, I draw upon MINSA policy documents and training manuals to organise a review of the health and social policy literature published on maternal health in Peru. In so doing, I describe how findings from the epidemiological literature have come to define the organisation, administration and delivery of maternal health programmes in rural areas of Peru. In order for the reader to situate my review, I begin by outlining the major policy initiatives relevant to maternal health that were introduced in 2009 and form the backbone of current maternal health programmes and strategies for intervention.

Health and social policy contributions to understanding maternal health and MMR in Peru

Plan Estratégico de Salud Sexual y Reproductiva 2009-2015

In 2009 the Ministry of Health introduced the *Plan Estratégico de Salud Sexual y Reproductiva* (Sexual and Reproductive Health Strategy). The strategy was initially designed to run until 2015: coinciding with the deadline for the achievement of the Millennium Development Goals. However, post 2015, with the transition to the Sustainable Development Goals, the plan continues to represent current maternal health policy in Peru and underpins continued government funded efforts to reduce

MMR in Peru. The *Plan Estratégico* was devised based upon recommendations emerging from epidemiological research (as described in the previous section) and has been key in the implementation and expansion of four major maternal health innovations specific to the Andean region. I have chosen to focus specifically upon these innovations precisely because they have had an enormous impact upon the way in which maternal healthcare is provided to and accessed by rural Andean women. These innovations are; the expansion of the *Casas de Espera Materna* (Maternal Waiting Houses) initiative, particular to the Andes region and designed to ensure that rural women agree to a clinically managed birth; the *Parto Vertical* (Vertical Delivery) initiative, guaranteeing vertical delivery techniques to Andean women giving birth in MINSA run clinics; the *Interculturalidad en Salud* (Interculturality in Health) initiative which seeks to promote respect and recognition of Andean birthing practices and enhance patient – practitioner relationships; and the creation of the *Juntos* cash transfer programme in impoverished areas which links Andean health policy and social development policies together for the first time. Having described the main contribution of each initiative in turn, I examine how the health and social policy literature has responded.

Casas de Espera Materna and Parto Institucional

One of the first initiatives to be implemented specifically in Andean regions was the *Casas de Espera Materna* (Maternal Waiting Houses)²¹ programme. With the clear message emerging from the epidemiological literature that women were dying in childbirth due to preventable obstetric emergencies (Starrs, 1987; WHO and UNICEF, 1996; Campbell and Graham, 2006), the Peruvian government had begun to finance the building of *Casas de Espera Materna* in 1997 with the assistance of UNICEF and USAID (MINSA/DGPS, 2006). The *casas* were initially provided specifically for pregnant women living in isolated rural areas whose access to skilled obstetric care was limited by virtue of their geographical location (MINSA/DGPS, undated, 13; MINSA/DGPS, 2006; MINSA, 2010; Ugaz, 2011). Hence, heavily pregnant women could spend several weeks or more housed in such accommodation (Fraser 2008:1233; Bristol 2009) prior to giving birth in a MINSA run clinic (Figure 8). In 2006, the Ministry of Health approved the *Casas de Espera Materna: Modelo*

para su implementación Technical Guide (Maternal Waiting Houses: An implementation Model)²², with the objective of improving pregnant women's access to health services by

...Guaranteeing them an institutionalised delivery and avoiding complications for those women with a history of obstetric risk by also guaranteeing their stay near to a health establishment. (MINSA/DPGS, 2006:13).



Figure 8: A Casa de Espera or Waiting House. Source: MINSA/DPGS Casas de Espera Implementation Guide, 2006:1.

The sign reads “Welcome to the Waiting House: an inn for pregnant women”. The accompanying portrait is of a highland woman in traditional dress.

In 2009, with the government in Peru acknowledging that transportation to health facilities and means of communication with healthcare providers for isolated, rural communities continued to be problematic (Fraser, 2008; Nureña, 2009; Callister 2009), the newly renamed *Casas Maternas* (Maternal Houses) construction programme was expanded as part of the *Plan Estratégico* (MINSA/DGPS, 2006; Andina 2010; La Republica, 2010; MINSA, 2010; Andina 2014) and their implementation standardized across the Andean region (MINSA/DGPS/DPVS, 2010).

Expansion also coincided with an increased drive to promote clinically managed birth (MINSA/DGPS, 2006; Nureña, 2009), known as *parto institucional* in Peru. This meant that Andean women, accessing maternal health services through their health

²¹ The *casas de espera materna* are also known in the Andes as *casas maternas*, *hogares maternas*: maternal homes, or by their Quechua equivalent *mamawasis*.

²² RM N° 674-2006 *Documento Técnico “Casas de Espera Materna: Modelo para su implementación”*, MINSA/DGPS.

insurance²³, were now expected to give birth in a MINSA run health establishment, rather than at home. The policy, following the MDG guidelines for access to emergency obstetric care (WHO, 2009), requires that all Peruvian women give birth in a clinic with a skilled health attendant present (MINSA/DGPS, 2006). As only particular clinics with the necessary life saving obstetric equipment and suitably qualified health professionals are authorized to attend institutional delivery in Peru (WHO, n.d.) this has had a marked impact on how rural women access maternal health. If they live in a remote village equipped only with rudimentary medical supplies and/or without the services of a skilled birth attendant, they are no longer permitted to give birth in their local *Posta de Salud* or health outpost. Instead, they must give birth in the clinic designated by MINSA to be suitably equipped (WHO, n.d). Rather than *choosing* to stay in their nearest designated ‘maternal house’ prior to going into labour and giving birth if they so wished, a stay in the *casa materna* now became obligatory for many rural women²⁴. By 2014 there were 456 *casas maternas* in operation in Peru, (Andina, 2014) the majority situated in rural populations across the Andean region²⁵.

Across the health policy literature, the expansion of the *Casa Materna* Programme was viewed as a positive step in Peru’s drive to reach its MDG5 target of reducing maternal mortality (Fraser, 2008; Bristol, 2009; Callister, 2009). Nellie Bristol argued that these “simple innovations” can mean the “difference between life and death for Peruvian mothers-to-be” (Bristol, 2009:997), her assumption being that the implementation of *casas materna* will lower the maternal death rate and thus produce an overall outcome favourable to the achievement of MDG5. Barbara Fraser (2008), writing in the *Lancet*, describes the *mamawasis* of the Cusco region as being “as similar as possible to the typical family home of an indigenous family in the district’s far flung farming villages” (2008:1233; see also MINSA, 2007; UNICEF, 2012:88),

²³ In 2009, maternal health cover was provided under the SIS or *Seguro Integral de Salud* (Integrated Health Insurance), replaced in 2010 by AUS: *Aseguramiento Universal de Salud* (Universal Health Insurance). See Arce (2009) for an overview of coverage.

²⁴ A report published by Physicians for Human Rights (2007) notes examples of coercion whereby indigenous women were expressly targeted to give birth in health establishments, such as the use of police and threats of incarceration in the Pampas Health Centre in Huancavelica. In addition *de facto* fines were also levied for issuing birth certificates when births occurred at home. I discuss the involvement of police and other authorities in Chapter 3 and 4, and fines levied for birth certificates in Chapter 6.

²⁵ *Casas Maternas* were also constructed in Amazonas, Loreto and other Amazonian regions in Northern Peru.

although contrary to Bristol, she noted that Peru was likely to fall short of the Millennium Development Goal to cut maternal mortality to 66 per 100,000 livebirths (2008:1233) due to critical problems in health service provision. Lynn Clark Callister (2009) reports that health facilities offering a “culturally friendly environment that simulated home” (2009:66) have seen a dramatic rise in use by rural women, following what she terms to be the aggressive pursual of MDG5 in Peru. Callister concludes that the

“innovative Peruvian experience is a great example of a creative way to provide birthing experiences that demonstrate respect for the sociocultural context of women's lives and honor their birthing preferences” (2009:66).

Statistics published by the Ministry of Health (MINSA) document a rise in institutionalised births from 59% in 2000 to 72% in 2007 (quoted by Fraser, 2008:1233), figures which appear to show that the *casas materna* are a successful intervention strategy: more women were accessing maternal healthcare in state run clinics. By 2015, MINSA statistics suggest a rise in institutional birth in rural areas from 57.6% in 2009, to 74.6% in 2015 (MINSA, 2016).

Health policy researchers have underlined that the drive to promote institutionalised birth has lead to a “pendulum shift” (Grady, 2009) away from the majority of births in rural areas being attended to at home by traditional *parteras* or midwives, to “nearly exclusively managed medical birth, centralised in government clinics in some areas” (Grady, 2009 in Zug, 2013:83; see also Nureña, 2009:372)²⁶. This fact has prompted the Ministry of Health – again responding to findings originating from the Peruvian epidemiological literature (see Parodi, 2005) - to forefront the importance of recognising cultural differences in healthcare (Nureña, 2009; Ugarte Ubilluz, 2009; Knipper 2010). The following section discusses the ways in which culture has been incorporated into MINSA driven maternal health initiatives.

²⁶ I examine the consequences of this shift in policy from the perspectives of rural women in the data chapters of my thesis.

'Interculturality in Health'

Acknowledging the socio-economic and geographical factors influencing maternal health outcomes, MINSA also positions culture as an important contributing factor to be considered:

...Barriers (to health) exist that are not only geographic or economic, but also cultural. These have to do with language, values, the mismatch with the western biomedicine model, the cosmovision of health and illness amongst indigenous and rural populations, ethics, and equality. In addition, non-discrimination for reasons of age, race, economic status, social class or gender, are all factors to be taken into account to guarantee Safe Maternity. (MINSA, 2006:11).

Thus, for the government and the Ministry of Health, the wide array of indigenous dialects and customs in Peru create a stark language and cultural barrier between the care provider and the pregnant woman (MINSA 2013). For MINSA, biomedical understandings of maternal health jar with Andean medicinal knowledge and practices and are compounded by gender and racial discrimination, preventing Andean women from accessing safe maternal healthcare. Attempting to improve the uptake of maternal health services in rural areas, the government introduced the *Interculturalidad en Salud* (Interculturality in Health) policy in 2009. The policy seeks to promote the “cultural adaptation of (maternal health) services to make them more attractive to indigenous women” (UNFPA, quoted in Fraser, 2008:1234). 'Cultural adaptation' is interpreted by the Ministry of Health and the government to include the training of health personnel in 'cultural awareness'; the availability of a quechua speaking (or other minority language) member of staff to be present at the health centre; and the inclusion of *parto vertical* (vertical delivery) as standard practice in the provision of maternal health services (MINSA 2005a; MINSA 1999; Nureña, 2009) at government sponsored clinics across the Andes region²⁷.

Following its introduction, *Interculturalidad en Salud* thus began to be discussed amongst academics and leading research bodies such as the INS within Public Health in Peru, with the explicit remit of examining 'cultural' attitudes to Public Health and their implications for inequalities of access (Arce, 2009). Maternal, neonatal and infant health has therefore become the focus for much recent 'culturally adapted'

²⁷ *Parto Vertical* is addressed in more detail in the following section of this chapter.

healthcare research in the Andes as culture has come to be positioned within Peru as an important influencing factor in health making decisions. César Nureña (2009:2) suggests that cultural barriers present a complex challenge to Peruvian maternal health provision. For Nureña, health personnel have scarce understanding of traditional medicine knowledge and practices, leading them to favour western biomedical health interventions, viewed by indigenous populations as “offensive and improper” (2009:2). Furthermore, in his critique of the Peruvian public health system, Nureña suggests that the fear and distrust felt by indigenous populations towards health personnel is very often caused by “prejudice, discrimination and cultural mismatch” between patient and practitioner, preventing them from seeking the health services they require (2009:2).

Academics, health educators and leading medical schools and universities within Peru, such as *Universidad de Cayetano Heredia* and *Universidad Nacional Mayor de San Marcos*, have also called for greater cultural awareness and sensitivity from health professionals, which has led to the publication of a body of literature within Peru endorsing the Interculturality in Health initiative as a strategy for improving uptake of health services amongst indigenous populations (Salaverry, 2010; Arce, 2009; Knipper, 2010; Ugarte Ubilluz, 2010). Maternal health in particular has been the focus of ‘culturally adapted’ strategies, designed to encourage ‘multi ethnic communities’ to participate in maternal health programmes within Peru (SSL, 2004; Quispe and Cordova, 2005; Nureña, 2009).

Health policy researchers examining Peru’s responses to high MMR have also identified ‘cultural barriers’ as making it difficult to obtain competent and empathetic care (Kayongo et al., 2006; Tarqui-Mamani & Barreda-Gallegos, 2006; Bristol, 2009; Callister 2009; Amnesty International 2009; in Zug 2013). Kayongo et al. (2006) describe various cultural adaptations to the provision of maternal health services in a government health post in Ayacucho, including signs posted in the local community language, the acquisition of birthing chairs, the encouragement extended towards family members to be present during birth, improved cooking facilities and improved privacy for patients (Kayongo et al., 2006:303-4). Health practitioners refer to women by their names rather than their bed numbers (2006:304). The authors state that previous interventions in the area were “unresponsive to the specific cultural needs of the women served which limited the utilisation of these services” (2006:306). This

lack of attention to patients' needs and absence of respect for “local cultures” is considered by the authors to be a deciding factor in the women's previous reluctance to use maternal health services in the area (see also Bristol, 2009; CARE, 2007; Gabrysch et al., 2009; Hunt and Bueno de Mesquita, 2010). However, Gabrysch et al., (2009) found that indigenous women *do* use delivery services if their needs are met, a factor that the authors suggest contradicts common ‘victim-blaming attitudes’ that ascribe high levels of home births to cultural preferences or ignorance (Gabrysch et al., 2009:724). Responding to such findings emerging from the health policy literature, the Ministry of Health expanded the *parto vertical* (vertical delivery) initiative to encourage Andean women to give birth in a health establishment, considered by MINSA to be suitably adapted to their cultural traditions.

Parto Vertical

MINSA recognises that *parto vertical* or upright delivery, has been the favoured birthing position for women since the Middle Ages (MINSA, 2005:16), and within Peru is the delivery position traditionally most often adopted by Andean women (MINSA, 2005b:16; Nureña, 2009:371), particularly amongst those choosing to give birth at home (Galarza, Alguilar and Flores, 1999; MINSA, 1999b; Nureña, 2009:371). *Parto vertical* was first offered to rural women choosing to give birth in MINSA run health establishments in 1996, coinciding with the launch of the first global Safe Motherhood initiatives and the WHO's recognition that the position has clear physiological advantages over horizontal delivery (WHO, 1996; MINSA, 2005b:16). Ministry of Health statistics indicate that during 2003, in Ayacucho, 2,300 home deliveries (28% of the total number of deliveries) were assisted by health personnel utilising the upright delivery technique (MINSA, 2005b:16). In Cajamarca 9.3% of total deliveries assisted by the healthcare personnel at home and at the healthcare facilities in 2003, were vertical deliveries. In 2004 the rate increased to 14.8% (MINSA, 2005b:16). Citing this statistical information, in 2005 the Peruvian government expanded the initiative across all Andean and Amazonian regions²⁸ in order to encourage institutionalised birth amongst rural populations (MINSA, 2005b).

²⁸ From 2005, *parto vertical* was to be offered in the Andean and Amazonian departments of Cusco, Cajamarca, San Martín, Huancavelica, Huánuco, Ayacucho, Puno, Apurímac and Amazonas (MINSA, 2005b:9).

In order to support the *parto vertical* initiative in government sponsored clinics, the Ministry of Health published the *Norma Técnica para la atención del parto vertical con adecuación intercultural*²⁹ in Spanish and its English equivalent, the Technical Guide for Vertical Delivery Assistance³⁰. The guide was designed to standardise medical procedures surrounding vertical birth across MINSA run health establishments, whilst simultaneously recognising the need for modifications to the way in which maternal healthcare is provided to indigenous women within MINSA run health establishments. Doctor Lucy del Carpio Ancaya, the National Coordinator for the Sexual And Reproductive Health Strategy in 2005, acknowledged in her introductory statement that,

“One of the cultural practices related to child delivery is the position that the woman adopts at the moment of labour. Most Andean and Amazon women prefer the vertical position either by squatting, sitting or kneeling, among others (traditional child delivery). Health professionals have been trained to treat patients in labour in a horizontal position (lying down). These two different practices produce a cultural disagreement between the healthcare professionals and the rural women, who often prefer to avoid going to the health institutions, risking their wellbeing and their life, as well as their unborn babies, if any difficulties may arise”.

(Technical Guide for Vertical Delivery, MINSA, 2005b:9)

In expanding the *parto vertical* programme, Doctor Del Carpio Ancaya underlines the importance of adjusting the healthcare services offered to women in order to increase institutional delivery and thus reduce obstetric complications that cause maternal death (MINSA, 2005b:9), citing statistics from the 2004 National Survey of Health and Demography that appear to show that there has been an increase in institutionalised birth in rural areas of Peru, up from 24% in 2000, to 44% in 2004 (MINSA, 2005b:9) after successful cultural adaptations to maternal healthcare services, such as the wider use of *parto vertical* techniques (MINSA, 2005b:9). To further encourage indigenous women to give birth in a MINSA health clinic, the government

²⁹ Norma técnica para la atención del parto vertical con adecuación intercultural ISBN 9972-851-22-2 Hecho el Depósito Legal No 2005-6714

³⁰ Technical regulation for vertical delivery care with intercultural adaptation (N.T. No 033-MINSA/DGSP-V.O1) / Ministry of Health. General Directorate of People's Health. National Sanitation Strategy for Sexual and Reproductive Health — Lima: Ministry of Health, 2005

introduced an additional measure, the *Juntos* programme which linked maternal health policy and social policy together for the first time.

Juntos

In specific Andean regions with a history of political violence³¹ and where the rural population has been recognised by the government to be suffering from extreme poverty (see Perova and Vakis, 2009a:4; 2011; 2012; Vargas Valente, 2010:23; Guzmán and Bethsabe, 2013; Perez-Lu et al., 2016) the government expanded the *Juntos* social welfare programme implemented in 2005³² (Arrospide, 2009; Diaz et al. 2009; Arroyo, 2010a; 2010b; Vargas Valente, 2010; Guzmán and Bethsabe, 2013; Perez Lu, 2016)³³. Families enrolled in *Juntos* receive a monthly allowance of 100 *nuevos soles*³⁴ (Jones, 2009) on condition they qualify according to individual or familial socio-economic criteria, in addition to regional poverty indicators and historical political violence³⁵ (Perova and Vakis, 2009b:4; 2011; 2012; Vargas Valente, 2010:24; Perez Lu, 2016).³⁶ Families enrolled in the programme agree to fulfil certain health commitments based on the Millennium Development Goals (Vargas Valente, 2010:24). For pregnant women in the Andes, enrolment in *Juntos* was dependent upon them attending antenatal appointments at their nearest *Posta de Salud* (Health Outpost) and agreeing to a *parto institucional* or clinically managed birth³⁷, staying in a *Casa Materna* beforehand if necessary. Quantitative assessments of the long and short term impacts of the *Juntos* programme indicated no statistical

³¹ See Orin Starn (1995;1999; 2003); Starn, De Greogori and Kirk (1995) and Starn et al. (1992) for anthropological perspectives on the political violence perpetrated in Peru in the Nineties.

³² In 2005 the programme served 70 districts (Perez Lu, 2016). This number gradually grew to 1097 districts in 2013 (60.1% of the 1838 districts in Peru), and currently benefits over 500 000 households (Perova & Vakis 2009a).

³³ For example, the *Juntos* programme operated in Chiara (one of my field research sites) in the Apurímac region but not in Izcuchaca (my second field research site) in the region of Cusco. I discuss the importance of *Juntos* for women from Chiara in Chapter 3.

³⁴ Approximately 20GBP

³⁵ See Vargas Valente (2010:24-25) for an overview of selection criteria based on socio-economic status and regional political history and an overview of commitments which participants in the programme must agree to.

³⁶ I discuss the linking of cash conditionality programmes with maternal health further in later sections of this chapter, and also in Chapter 3.

³⁷ Cookson (2016) defines clinic based birth as being a 'shadow conditionality' – an unofficial requirement of the *Juntos* programme. However she points out health officials and programme supervisors were in disagreement over this point (Cookson, 2016) In Chiara, where I carried out my research, women were regularly economically sanctioned, publically berated and removed from the programme for failing to give birth in a clinic: concerns I discuss in Chapter 3. Health professionals with whom I worked in Izcuchaca (where *Juntos* did not operate) told me that clinic based birth was made obligatory in Peru in 2009.

change amongst women giving birth in medical facilities or attending medical centres for antenatal checks in 2009 (Perova and Vakis, 2009b:18); by 2012, doctor assisted delivery had improved by 91% and contraception use increased by 12% (Perova and Vakis, 2012; by 2015, beneficiaries of the *Juntos* programme were complying with the requisites of the programme in relation to institutionalised birth (Perez Lu, 2015:9; see also Trivelli & Díaz 2010; del Pozo & Guzmán 2011; Escobal & Benites 2012a, 2012b; Perova & Vakis 2012).

Thus, in 2009, under the auspices of the National Health and Reproductive Strategy, the Ministry of Health was vigorously promoting *parto vertical* hand in hand with its Interculturality in Health strategy to encourage Andean women to give birth in MINSA run health establishments, which were equipped to provide EMoC. The expansion of *Juntos* allowed the Sexual and Reproductive Health Strategy to be directly linked to social welfare and development policies for the first time, with particular populations of Andean women being encouraged to participate in maternal health programmes under specific socio-economic and historical political conditions and in return for financial reward, provided they fulfilled their commitments to the programme³⁸.

Policy researchers investigating maternal health in Peru underline that the Sexual and Reproductive Health Strategy has not been routinely implemented across the nation and systemic health inequalities remain (MINSA 1999; Loayza Condori 2003; Calisaya 2004; CARE 2007; Camacho, Castro and Kaufman, 2006), for ethnic minority groups (PHR, 2007; Fraser 2008; Camacho, Castro and Kaufman 2006; Bristol, 2009; Knipper 2010), with regard to gaps in service delivery and patients' utilisation of services. Alicia Yamin, reporting for Physicians for Human Rights (PHR) in 2007, underlines the divide in maternal health service provision between urban and rural populations across Peru: in urban areas the interventions needed to treat obstetric emergencies and therefore to prevent the great majority of maternal deaths, are well known and “readily available” to women of economic means, In contrast, the lack of available, accessible, acceptable and quality obstetric services in rural areas leads to delays in the decision to seek care, in arriving at care and in

³⁸ The expansion of the *Juntos* programme followed the trend across Latin America and the global South. By 2014, there were 52 countries with some form of Cash Conditionality Transfer (CCT) in operation, 17 of them in Latin America (Lamanna, 2014).

receiving appropriate care (Thaddeus and Maine, 1994). For Yamin, indigenous women are disproportionately affected not only by the interactions of rural poverty, geographical location and gender inequality, but “the way in which the health system exacerbates those patterns of exclusion”. (PHR, 2007:5).

In addition, the PHR study suggests that rural indigenous women who die - and their family members - are often blamed for their own deaths due to their decision to delay seeking care with MINSA ascribing the delay to “cultural preferences”, pertaining to the high percentage of home births in rural areas (PHR, 2007:9). Inequitable distribution of healthcare facilities, goods and services; poor quality of care; economic barriers to access for impoverished families; lack of cultural sensitivities and acceptability of care at health facilities; provoke delays in seeking care (PHR, 2007:10). Discriminatory attitudes towards indigenous women seeking maternal healthcare in state run clinics have also been recognised in other studies (Kayongo, et al. 2006; Bristol, 2009; Fraser, 2008), illustrating the challenges faced particularly in rural areas of Peru in realizing indigenous women’s right to safe motherhood. CARE, an NGO working in the maternal health arena in Peru, has criticised the health services of large areas of Peru for “not having made the effort” to put into practice the culture-centred policies advocated by the Peruvian government (CARE, 2007).

Authors like Kayongo et al. (2006), Yamin (for PHR, 2007), and Gabrysch et al. (2009) thus direct attention to social inequalities when dealing with maternal healthcare issues in Peru. They show that the shortfalls in the Peruvian health system are rooted historically, socially and politically, and that recent attempts to improve it have failed to address fragmentation and inequity in access to services – problems that reflect the socio-economic inequalities which structure Peruvian society more broadly. In doing so, this literature helps us to situate the problem of maternal health and mortality in the political economy of welfare in Peru, providing an important insight into the broader socio-political structural issues underpinning MMR across Peru.

However, this body of research does not account for the experiences of individuals, families and communities accessing maternal health within an inequitable system. An examination of the qualitative health literature allows us to gain a greater understanding of patients’ individual experiences, thus complementing the insights

provided about the policies and structure of the health system and its problems emerging from health and social policy literature. Thus, to learn about the lives of those who rely upon these institutions, in the next part of this chapter I will therefore review contributions from qualitative scholarship that attempts to shed light specifically on the experiences of women accessing maternal health in the Andes.

Qualitative health research: the individual's experience of maternal health

Taken together, the bodies of epidemiological and health and social policy literature presented above offer ways of quantifying the scale of the problem of MMR, its distribution across the population and institutional sites, how policy measures are designed to tackle the incidence of MMR in Peru, shedding light on the structural and systemic difficulties in so doing. An examination of the qualitative literature complements these perspectives allowing us to learn about individuals' experiences of maternal health. A growing number of qualitative studies in Peru, emerging from nursing and sociology disciplines, seek to explore the individual experiences of health professionals and their patients; their opinions and feelings; and the factors influencing their decision making when choosing to access (or not) maternal health services in Peru.

MINSA's current emphasis on promoting Interculturality in Health (as discussed in the previous section), has generated recent qualitative studies that investigate users' and service providers' perceptions and experiences of the intercultural adaptations made to healthcare in Andean and Amazonian regions (Mayca et al. 2009; Valenzuela Ore et al., 2015; Aliaga Rodriguez, 2014; Sumeriski, 2016). Mayca et al. (2009) show that although health professionals recognised that the introduction of intercultural initiatives such as the *casas maternas* and *parto vertical* had lead to improved professional relationships with patients, and encouraged greater use of health services, nevertheless inadequate health infrastructure was a concern. Health professionals cited language barriers and the financial cost in maintenance and upkeep of the *Casas Maternas*, and the lack of necessary equipment to adequately attend to patients requesting *parto vertical* as having a negative effect on patients' experiences. In the same study, patients cited lack of cultural adaptation of health services to their needs, a failure to understand how to use the medication prescribed to them and fear of

clinically managed birth as impacting negatively on their experiences. Mayca et al. (2009) concluded that Peru's maternal health services in rural Andean regions are insufficiently culturally adapted. The authors recommend working alongside indigenous populations to create maternal health services that community members can identify "as their own", incorporating important social, cultural and ethnic aspects.

Felix Valenzuela Ore et al. (2015) employed both quantitative and qualitative research methods to investigate users' perceptions of health services from an intercultural perspective in the Andean region of Huancavelica. Surveying and interviewing both health service users and providers, in addition to traditional midwives, the study found that 44% of users had never participated in the planning and prioritization of health activities; 85% reported that they had been 'fined' by service providers for giving birth at home³⁹; 77.2% reported that healthcare is provided on condition that women actively participate in social programmes such as *Juntos* (discussed above)⁴⁰. The authors conclude that there are deep divisions between the Andean community where the study took place and the service providers, described as "representatives of the modern and hegemonic state" (Valenzuela Ore et al., 2015:22). The authors attribute these divisions to cultural misunderstandings, reporting that users have negative perceptions of service providers because health providers do not encourage service users to participate in health initiatives, instead imposing fines and penalties that carry grave economic consequences for families. Equally a lack of "intercultural competence" (2015:22), whereby health professionals fail to establish relationships with users based on mutual respect for cultural traditions exacerbates problems. Andean communities are not encouraged to articulate their own healthcare needs, nor participate in the designing of culturally adapted healthcare programmes under current health regulations. These factors further broaden the gap in users' and providers' perceptions in the authors' opinion (Valenzuela Ore et al. 2015: 22).

³⁹ I describe and discuss the various sanctions levied against women choosing to give birth at home in Chapter 3 of this thesis.

⁴⁰ Chapter 3 examines *Juntos* and its consequences for pregnant women enrolled in the programme in Chiara.

Kasey Sumeriski (2016) carried out qualitative research in a health establishment located in the Cusquenian town of Huancarani. With a focus on intercultural health, her study examined the factors facilitating and limiting the integration of biomedicine with traditional medicine in addition to the factors inhibiting the translation of interculturally adapted healthcare into clinical practice in the health outpost. Interviewing health professionals, patients and traditional health practitioners, her study identified lack of education, training, and respect as factors limiting the successful translation of intercultural medicine policies into clinical practice (2016:3). She draws attention to the discrepancies in views expressed between health professionals, traditional practitioners and patients and highlights the disconnection evident between them (see also van Dijk et al., 2013, on Guatemala). The study concludes with recommendations to improve communication between government bodies such as the *Centro Nacional de Salud Intercultural* (CENSI: National Centre for Intercultural Health)⁴¹, and regional government, health professionals and the communities they serve.

Sumeriski's findings are also reflected in other recent qualitative research. Lyliana Rodriguez Honorio (2015) investigated attitudes to and knowledge of *parto vertical* amongst obstetric undergraduates at the State University of San Marcos in Lima. She found differing attitudes towards *parto vertical* amongst trainee obstetricians, with 65.7% in favour of the technique and 34.3% against it. In terms of employing the technique to assist women giving birth, 85.6% were against it, as they felt they were insufficiently prepared and trained in the technique. However, 73% of interns interviewed considered the intercultural aspects of *parto vertical* as beneficial and were of the opinion that it should be practiced and promoted nationally and not only limited to rural areas of Peru. 71% of interns said they would respect a women's choice to give birth using the *parto vertical* method (Rodriguez Honorio, 2015:5).

⁴¹ CENSI is a branch of the INS, the National Research Institute in Peru. It describes its principal objective as being:

“to promote intercultural policies, strategies and health norms, in addition to research into the successful integration of traditional medicine, alternative and complimentary medicine with academic medicine, respecting the multi-ethnic character of (Peru) and improving the health of Andean and Amazonian populations within the framework of the right to intercultural health”.

<http://www.portal.ins.gob.pe/es/censi> (Accessed 3rd December 2016).

Cynthia Velasquez-Ramirez and Manoloa Rios-Flores (2015) investigated the experiences and perceptions of Amazonian women giving birth utilizing the *parto vertical* (upright delivery) technique. Their study showed that for Amazonian women, *parto vertical* is closely associated with home birth, being the traditional way of giving birth in the Amazon. The majority of women participating in the study were of the opinion that *parto vertical* did not have disadvantages for mother or child, but rather was advantageous in that they had not experienced complications, difficulties, suffering or pain during the birth; they had scarcely bled and they found the technique comfortable, resulting in a rapid birth. Those women who did not attend the clinic to give birth reported that they chose not to because they felt their customs were not respected there (Velasquez-Ramirez et al. (2015:vi).

Aside from intercultural health, an emerging body of recent qualitative literature has examined the experiences of participants enrolled in the *Juntos* development programme (Vargas and Salazar, 2009; Aramburu, 2010; Vargas Valente, 2010; Bernardo Jimenez, 2014) and its impact on their experiences of sexual and reproductive health provision and access in Peru (see Perova and Vakis, 2009a; 2009b; Arroyo, 2010a; 2010b; Vargas Valente, 2010; Molyneux and Thompson, 2011; 2007). Teenage pregnancy, male abandonment and widespread violence against women⁴² were reported by women as factors contributing to them having limited control over their reproductive lives and limited access to mechanisms to ensure the fulfilment of their reproductive rights (Vargas Valente, 2010; see also UN, 1948; 1976; 1993; WHO, 2014)⁴³. Some participants reported that the *Juntos* programme reinforces traditional gender roles and vulnerability for rural women, (Molyneux and Thompson, 2011), others noted its' paternalistic approach (Vargas Valente, 2010) whilst also acknowledging the unexpected empowering effects for women (Vargas Valente, 2010). For Rosana Vargas Valente (2010), the design of the programme reinforces both women's traditional role in the household and time poverty by relying on women to be responsible for children's wellbeing. However, Vargas Valente also highlights that *Juntos* has increased women's access to family planning services and,

⁴² See also Murray de López, 2015; Boesten, 2014; Castro R., 2014; Berry, 2013; Smith-Oka, 2013, de Zordo, 2012; Castro A., 2004; Dalsgaard, 2004; Diniz and Chacham, 2004; McClusky, 2001; for anthropological perspectives on gender based violence in Latin America.

by giving the cash transfer directly to women, has enhanced their decision making capacity at household level, their self-esteem and recognition (Vargas Valente, 2010; 8).

Maxine Molyneux and Marilyn Thompson (2011; 2007) also explored Andean women's experiences accessing healthcare via three cash transfer programmes in Latin America⁴⁴. In relation to maternal health, women in Peru and Bolivia complained of frequent mistreatment⁴⁵ and long waiting times at the health centres, especially problematic for those who have to walk for several hours to get to the services. There were also tensions with respect to the requirement that women should give birth in the health centre. Although having a hospital birth is not an official condition of the programme in Bolivia, in practice, women can be temporarily suspended if they have a home birth⁴⁶ (Molyneux and Thompson, 2011:13). The authors also found that the *Casas Maternas* are not always accepted by the women they are intended for because they have to leave their families and daily chores such as caring for livestock⁴⁷. The cash transfer programmes included some measures to follow customs and cultural practices in hospital births, such as the inclusion of *parto vertical*, the use of traditional medicinal herbs, and the presence of a close relative during the birth (Castro 2010). However, Molyneux and Thompson (2011) found that this respect for some cultural practices did little to offset women's sense of a lack of understanding between them and the hospital staff. Molyneux and Thompson indicate that the lack of trust and fear of mistreatment means that some indigenous women prefer to give birth at home rather than seek care in a health establishment (see also Bohren et al., 2015; Chadwick, Cooper and Harries, 2014; Moyer et al., 2014; El-Nemer, Downe and Small, 2006), where they also have access to traditional birthing assistants (Castro 2010; Molyneux and Thompson, 2011).

⁴³ I discuss these findings further in Chapter 5.

⁴⁴ The research looked at the *Juntos* Programme in Peru, *Bono de Desarrollo Humano* in Ecuador, and *Bono Juana Azurduy* in Bolivia.

⁴⁵ Mistreatment during delivery is a common theme in the global qualitative maternal health literature. See D'Ambruoso, Abbey and Hussein, (2005) and Moyer et al., (2014) exploring mistreatment of women in labour in Ghana; Janevec et al., (2011) on racism directed towards Romani women accessing maternal healthcare in the Balkans; McMahon et al., (2014) on mistreatment of both men and women in healthcare facilities in Tanzania; Turan et al., (2008) on how mistreatment of women has affected uptake of maternal health services in Kenya; Human Rights Watch (2011) on abuses during delivery in South Africa and Bowser and Hill (2010) for a global analysis of disrespect and abuse in delivery facilities during childbirth.

⁴⁶ My research also showed that in practice this is also the case in Peru, see also Cookson, (2016).

Jessica Bernardo Jiménez (2014) reported both positive and negative experiences by participants in the *Juntos* programme operating in San Jose de Quero between 2010 and 2011. She found that women reported increased attendance for antenatal appointments and institutionalised births in the region, but felt that *Juntos* was also responsible for exacerbating barriers between themselves and health personnel, citing a disregard for intercultural healthcare, and discriminatory attitudes of health personnel towards the local population. Bernardo Jimenez suggests that the majority of health workers in the clinic in San Jose de Quero infantilise the rural population. For Bernardo Jimenez, such a perspective limits the empowerment of women and accentuates shortfalls in healthcare and cultural barriers to health in its failure to promote strategies based on mutual respect for rights and the development of what she terms “*conciencia ciudadana*” (citizen awareness) designed to emphasise the idea of co-responsibility in health between the State and the population (Bernardo Jimenez, 2014:25; Meltzer, 2013)⁴⁸.

In fore fronting personal experience, the qualitative research I have reviewed here highlights difficulties and challenges for users and service providers alike when general policy guidelines are implemented in local contexts. Researchers such as Mayca et al. (2009), Velasquez-Ramirez and Rios-Flores (2015) and Valenzuela Ore et al. (2015) show that rather than providing a solution to Peru’s MMR problem, the Interculturality in Health policy is a tension point between patients and practitioners as both vie with the intricacies of the policy as it plays out in practice. Designed to enhance patients’ maternal health experiences and improve quality of care across clinical spaces, intercultural initiatives are hampered due to lack of health infrastructure and professional training, limiting practitioners’ attempts to incorporate cultural adaptations such as *parto vertical* into their health practices (Rodriguez Honorio, 2015; Sumeriski, 2016). In addition, patients feel that they are not sufficiently consulted as to their cultural needs (Mayca et al., 2009). When cultural adaptations are not implemented, patients therefore prefer to continue to give birth at home (Molyneux and Thompson, 2014; Velasquez Ramirez et al., 2015). Further, the non-participatory approach to healthcare exacerbates the distance felt between patient

⁴⁷ I address this important issue in Chapter 3.

and practitioner in rural health outposts (Valenzuela Ore et al., 2015). The qualitative research reviewed also highlights differences in opinion regarding the success and shortfalls of the *Juntos* programme, which again are not immediately apparent from a reading of the policy literature. Some qualitative researchers forefront the empowering effects the programme has had on female beneficiaries in giving them control over their finances (Vargas Valente, 2010) and yet women enrolled in the programme also remain vulnerable to instances of discrimination and a lack of respect shown to them by programme coordinators (Bernardo Jimenez, 2014). The conditionalities and fines imposed on programme members in particular, carry grave economic consequences for impoverished rural women (Valenzuela Ore et al., 2015).

As a final note on this form of research, the majority of these studies are applied: their objective is to inform maternal healthcare practice and improve quality of patient care, valuing evidence based medicine, practice and policy in the treatment of patients. While this is without doubt positive, by virtue of their location within that domain, these studies lack a social scientific orientation and hence fail to capture the complex lived realities of illness experience (where subjects suffer more than a single ailment, for example), biological variation and cultural influences that exist outside of the controlled environment of the clinic. A growing body of literature exists that is positioned in a more critical and interpretive perspective, one that draws on ethnography to explore different dimensions of maternal health provision and access cross-culturally, incorporating and valuing patient knowledge within its analysis. This literature is the focus of the last part of this chapter.

Ethnographic Perspectives on providing and accessing Maternal Health

The qualitative studies reviewed in the previous section emphasise the importance of the individual's experience. However, the individualizing nature of these studies means that they tend to overlook the critical importance of cultural context into which personalized experiences are deeply embedded. An ethnographic perspective allows us to consider the individual's experience whilst also paying careful attention to the socio-cultural domains and social relations that impact greatly upon lived experience. Situating maternal health in the context of lived experience and in field-based

⁴⁸ I discuss notions of responsibility specifically in relation to maternal health in Chapter 3 and 4.

ethnography enables us to see the social and cultural effects of reproductive policies as they are understood and lived ‘on the ground’. This perspective is important as it enables an identification of the gaps in the understanding of policy makers (Standing, Oronje, and Hawkins, 2011).

Accordingly, a large ethnographic literature exists within medical anthropology and the social sciences, which attempts to provide a more integrated understanding of maternal health in contexts by explicitly expressing the everyday lives of women within the social, cultural and political domains within which maternal health interventions take place. Ethnographers have addressed biomedical technologies and obstetric interventions, biopolitics, social justice and human rights, kinship, conceptions of body, self and identity, life and (maternal or neonatal) death, and the commodification and stratification of human reproduction (Smith Oka, 2009; 2012a; 2012b; 2013; Berry, 2005; 2013; Overall, 2012; Morgan and Roberts, 2012; Krause and de Zordo, 2012; Goldade, 2011; Ewig, 2010a; 2010b; Colen, 2009; Soto Leavaga, 2007; McCormack 2005; Chavez, L., 2004; Dudgeon and Inhorn, 2004; Castro and Erviti, 2003; Larme and Leatherman, 2003; Rapp, 2001; Larme, 1997; Ginsburg and Rapp, 1995; Sesia, 1992; 1996; Scheper-Hughes, 1993; 1985; Cosminsky, 1982). I will not review all the ethnographic work cited above but instead have chosen to organise my review into three sections, describing and critically appraising three recent dominant themes emerging from the ethnographic literature on maternal and reproductive health particularly relevant to my study. The first body of work reviews cross-cultural perspectives on obstetric and midwifery practices (Kvernflaten, 2013; Smith-Oka, 2013; Berry, 2013; 2010; 2005; Purnell 2002; 2012; Glej, Goldman and Rodriguez, 2003; De Vries et al. 2002; Davis-Floyd, Pigg and Cosminsky, 2001; Davis-Floyd and Sargent, 1997; Jordan, 1978); the second examines the structural violence underpinning reproductive health (Aggleton and Parker, 2010; Bailey, 2011; Correa, Petchesky and Parker, 2008; Farmer, 2003; Scheper-Hughes, 1993) responding to calls for social and reproductive justice (Unnithan, 2013; Luna and Lukar 2013; Unnithan and Pigg, 2014) amid a renewed emphasis on human rights in reproductive health policy; the third examines the biopolitics of maternal health (Smith Oka, 2009; 2012a; 2012b; 2013; Overall, 2012; Morgan and Roberts, 2012; Krause and de Zordo, 2012; Berry, 2010; Ewig, 2010; Colen, 2009; Soto Leavaga,

2007; Goldade, 2009; 2011) drawing particular attention to ‘stratified reproduction’⁴⁹ (Soto Leavaga, 2007; Colen, 2009), and ‘reproductive governance’⁵⁰ (Morgan and Roberts, 2012). As there is a limited quantity of recent ethnographic research from Peru, I have widened my review to include research from Latin America and the global south, which serves to highlight parallels between current maternal health provision for women in Peru, and their counterparts elsewhere.

Lived experiences of maternity in cross cultural contexts

Brigitte Jordan’s comparative ethnography “Birth in Four Cultures” (1978), was the first to study childbirth practices from a cross-cultural perspective whilst drawing particular attention to the biosocial framework within which birth takes place. Jordan’s study emphasised that pregnancy and birth is a phenomenon not only biological in nature, but one which is influenced by the particular society and the interactional context where delivery takes place, and that - in terms of maternal health - biology, society, and context must be considered together (Jordan, 1978:3). Since the publication of Jordan’s ethnography, childbirth and reproduction have emerged as vibrant areas of ethnographic research in medical anthropology, with the ‘anthropology of midwifery’ (Davis-Floyd, Pigg and Cosminsky, 2001) in particular being the focus of much ethnographic research.

Consequently a wealth of cross cultural studies investigate not only local birthing customs, but also the complex web of negotiations taking place between the birthing woman, her family, traditional birth attendants (TBAs) and biomedically trained health professionals⁵¹. Ethnographers thus draw attention to the conceptualization of birth, the importance of considering local understandings, specific local practices and emergent issues as maternal health is negotiated across differing cultures, amongst different populations and in diverse local settings and contexts (Purnell, 2002; de Vries et al., 2002; Davis-Floyd and Sargent, 1997). Davis-Floyd, Pigg and Cosminsky

⁴⁹ Shellee Colen (1995) termed “‘stratified reproduction’” to describe the ways in which certain social groups are encouraged, supported, and enabled to reproduce while others are discouraged from having children.

⁵⁰ Reproductive governance refers to the mechanisms through which different historical configurations of actors – such as state institutions, churches, donor agencies, and non-governmental organisations (NGOs) – use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviours and practices (Morgan and Roberts, 2012:243)

⁵¹ See Davis-Floyd, Pigg and Cosminsky (2001) for an overview.

(2001) draw attention to the diversity documented across such an array of ethnographic studies. They argue that such diversity challenges the essentialising Western stereotyping of midwives, which variously promote all midwives as “woman-centered, caring, and technologically superior”, or the reverse argument which promotes “the institutionally embedded demonization of all forms of non-biomedical birth assistance as harmful and medically dangerous”. (2001:107). These oversimplifications, backed up by public health statistics highlighting the physical cost of childbirth, ignore the moral and cultural stakes involved in childbirth. The authors posit that birth can go ‘wrong’ in moral and cultural terms too, invoking further pain and suffering:

“Safety, survival, physical and emotional comfort, control, respect, status, values, and auspiciousness may all be involved in childbirth in tangled, culturally specific ways. What is “best” for birthing families cannot be determined by one-size-fits-all programs and evaluations. When knowledge systems diverge, women and families must sometimes make trade-offs between their assessment of how to ensure the survival of mother and baby and their assessment of how to achieve the comfort of a socially valued form of birth; and they don’t always make the choices that fit the worldviews of their caregivers, health planners, or the state-supported medical system that organizes the possibilities available to them” (Davis-Floyd, Pigg and Cosminsky (2001:107).

Echoing the findings of Davis-Floyd, Pigg and Cosminsky (2001), cross-cultural ethnographies in Latin America have shown the importance of local cultural understandings, knowledge and practices in women’s maternal health decision making. Programmes and health interventions that fail to consider local cultures risk failure. For example, in rural Guatemala, despite attempts to incorporate medically pluralistic initiatives into Guatemalan healthcare (see Pedersen, 2007; Mosquera Saravia, 2006; Mosquera Saravia and Kolstrup 2006; Pisquiy, Gallegos and Lix Socop, 2004; Gleit, Goldman and Rodriguez, 2003; Mignone et. al., 2007; Cosminsky, 1982), only 13% of women give birth in a hospital, the majority still preferring the services provided by the *comadrona*, the traditional midwife (Chomat et. al., 2014). Partnerships between indigenous authorities, community midwives, key local actors and Organisations to foster cultural exchange and awareness raising to improve maternal healthcare provision for indigenous women face difficulties due to lack of

integration into nationwide healthcare practice; tense relationships between formal and traditional maternal health service providers due to social, ethnic and cultural differences; a strong history of discrimination and devaluation of indigenous knowledge and practices (Glei, Goldman and Rodriguez, 2003; Hurtado and Saenz de Tejada, 2001 in Guatemala; Medina and Mayca, 2006; Chavez Alvarez et al., 2007; Yajahuanca et al., 2013; Portocarrero et al., 2015 in Peru).

Further, midwifery-training programmes in Guatemala have been criticised for their emphasis on the modification of local midwifery practices (Berry, 2013; 2005; Stephens et al. 2006; Lang and Elkin, 1997; Cosminsky, 1982). Nicole Berry (2013; 2005;) emphasises that some training programmes ought to be recognised for their “progressive” and “innovative” nature (Berry, 2005:e1), encouraging lay midwives trained by public health workers to share Ministry of Health educational materials in order to train other lay midwives. However, there is still an expectation that lay practices must adapt to the dominant obstetric model. For Guatemala’s Ministry of Health, getting women to the hospital when they are experiencing an obstetric emergency is understood to mean changing lay midwifery practices, so that midwives begin making early referrals of clients who have or are likely to have problems (Berry, 2005:e2). The key to making the referral process work, the Ministry believes, is by educating midwives. The theory is that if midwives are taught to correctly recognise danger signs, they will make timely referrals that can save women’s lives (Berry, 2013; 2005).

However, ethnographers working in Guatemala underline the need for a bidirectional flow of knowledge between the formal and traditional sectors of maternal healthcare (Berry, 2013; 2005; Glei, Goldman and Rodriguez, 2003). Equally, in Peru, there is an urgent need for coordinated and horizontal working relationships between both systems (Portocarrero et al. 2015) following the move to institutionalised birth in 2009 (see Health and Social Policy) which devalued the work of the community *partera* (midwife), particularly in light of WHO’s classification of skilled birth attendants which excludes traditional *parteras* (WHO, n.d; Sibley and Sipe, 2006; Harvey et al. 2004; Bergstrom and Goodburn, 2001; Starrs, 1998; Maine, 1993).

Berry’s (2013; 2005) ethnographic research further underlines how global maternal health policies fail to meet the needs of rural women in Guatemala, threatening to

disenfranchise rural women utilising health services from their cultural understandings of self. Berry suggests that global policies need to be incorporated in harmony with the everyday lives of local women and posits that a failure to do so will result in a failure to decrease maternal mortality globally. Designing policies based around biomedical interventions are “fruitless” (2005:195) without first taking stock of what women and their families want and need to make birth safer.

In Nicaragua, Brigitte Kvernflaten's (2013) ethnographic fieldwork also examines the redefined role of the *partera* after Nicaragua became a signatory to the Millenium Development Goals. Her work illustrates how state supported medical systems focussing on reducing maternal mortality do not always meet the needs of local women despite their best efforts to facilitate cross cultural healthcare. She argues rather than facilitate cross cultural healthcare, instead traditional birth attendants and community health workers in Nicaragua have become ‘agents of MDG5 achievement’, their role having been narrowed to identifying pregnant women and advocating institutionalised delivery. Negative and unintended implications for the relationships between women, local volunteers and the formal health system result: traditional birth attendants and community health workers report feeling fear that they will be held responsible in the event of a maternal death; increased dissatisfaction with their role and reduced motivation result. She concludes that target orientated global policy initiatives such as MDG5 have led to a prioritisation of narrow indicators at the expense of more comprehensive approaches.

Ethnographies examining lived experiences of midwifery and obstetric practices in Latin America thus offer new perspectives on maternal health not apparent from a reading of the epidemiological, policy and qualitative literatures, revealing gaps in the understanding of policy makers (Standing, Oronje, and Hawkins 2011). Despite efforts to promote cultural empathy through midwifery training programmes in Guatemala and Nicaragua (see Kvernflaten, 2013; Mignone et al., 2007; Glei, Goldman and Rodriguez, 2003; Cosminsky, 1982), and the implementation of healthcare initiatives designed to simultaneously foster respect and recognition of local birthing practices amongst health practitioners whilst facilitating access to obstetric care for women in Latin America (Berry, 2013; 2005), the ethnographic work reviewed above shows us that state run intercultural initiatives do not always ‘bridge the gap’ between obstetric clinic based practices and local birthing customs

and knowledge, often failing to meet the needs of the women that they are intended for (Berry, 2005; Portocarrero et al. 2015).

Structural Violence, Social and Reproductive Justice

Aside from studies investigating midwifery and obstetric practices, anthropologists have also linked maternal health outcomes with social injustices emerging from the organisation of their social world (Unnithan, 2015; Unnithan and Pigg, 2014; Schoenfeld and Juarbe, 2005; Scheper-Hughes, 1993). Paul Farmer's work has influenced anthropologists, in clearly illustrating the links between large-scale social forces such as racism, gender inequality, poverty, political violence and war, and sometimes the very policies that address them, that often determine who falls ill and who has access to care (Farmer et al., 2006:e449). Using the term "structural violence" (Farmer, 2005; 1996) to describe the systemic, social and economic conditions that lead certain people to fall ill compared to others, Farmer's political economic perspective on health suggests that the poor are most likely to bear the burden of illness, for poverty predisposes individuals to fall ill (as he observed in his work on the social patterns that facilitated the spread of HIV in Haiti in the late 1980s and the 1990s) (Farmer, 2005; 1998). Farmer's work is important because it focuses on the structural nature of health abuses. His structural violence framework has been taken up by anthropologists seeking to investigate how health issues become inextricably intertwined with rights, particularly social and economic rights (Farmer, 2005: 217; Unnithan, 2015: 51). Assessing the impacts of rights-based interventions on (maternal) health, Maya Unnithan advocates the pressing need to move beyond community settings and to reflect instead upon the wider state structures and how these may be connected to systemic processes where discrimination is inherent (Unnithan, 2015: 51). She draws on Farmer's term, "pathologies of power" (Unnithan, 2015:46, Farmer, 2005; 1999) to describe human rights violations that occur when the workings of state power combine with structural violence to determine who will be at risk of human rights assaults and who will be shielded from them (Farmer, 1999).

After Farmer, employing structural violence as a framework to examine reproductive health, ethnographers in Latin America and the global south show how culture, economic deprivation and resulting poverty interact to influence maternal health

outcomes (Correa Aste and Roopnaraine, 2014; Bailey, 2011; Aggleton and Parker, 2010; Ewig, 2010; Correa, Petchesky and Parker, 2008; Nations, 2008; Schoenfeld and Juarbe, 2005; Larme and Leatherman, 2003; Farmer, 2003; Larme, 1997; Scheper-Hughes, 1993; 1985). Their work highlights how economic hardship and maternal deprivation, material and emotional scarcity are inextricably linked. Women in rural Ecuador cite lack of money, the burden of poverty and physical hardship as important contributory factors to poor health (Schoenfeld and Juarbe, 2005), also linking their ill health to emotional conflict or mistreatment at home, perceiving that “*mejor es estar sola*”, they are “better off alone” (2005:966-7). In Peru, Anne Larme and Thomas Leatherman (2003) link women’s reproduction to structural violence, arguing that in impoverished rural societies women are particularly vulnerable to the ways in which high fertility, heavy workloads, marginal nutrition and living conditions compromise their reproductive health. They suggest that women in highland regions classify and respond to reproductive illnesses as a means to articulate the myriad of daily struggles they face each day (Larme and Leatherman, 2003, see also Schoenfeld and Juarbe, 2005). By placing “culturally interpreted illnesses” (2003:192) such as *Sobreparto*⁵², within their social and political-economic context, the authors illustrate the multiple dimensions of the complaint as *Sobreparto* intertwines with many aspects of their work and social lives.

Earlier ethnographic work by Anne Larme (1997) investigating the gendered allocation of healthcare resources in the Andes, suggests that female children in the Andes are valued less by parents because of their limited future social and economic potential. Larme argues that selective neglect (passive infanticide) may be occurring in rural Peru, with Andean mothers harnessing ‘folk illnesses’ (Larme, 1997:1711) to explain infant death in a manner “culturally acceptable” to them. However, she underlines that it is important to go beyond placing blame on individual parents or on culture, emphasising instead the underlying causes of differential healthcare allocation, such as poor socio-economic conditions, lack of access to contraceptives and female subordination in the home that condition patterns of discrimination against female offspring and younger children. Her research echoes the earlier ethnographic work of Nancy Scheper-Hughes who found that the harsh socio-economic reality of

52 There is no direct translation into a biomedical condition. However literal translation into English would be “too much childbirth” (my translation).

life lived in a Brazilian shanty town shapes maternal beliefs, sentiments and practices amongst an impoverished migrant community (Scheper-Hughes, 1985); feelings of attachment, separation and loss are negotiated by Brazilian mothers as they allow some of their children to die *a mingua*: without care or attention (ibid). However, Marilyn Nations (2008) questions the validity of the assumption that selective maternal negligence is a relevant explanation (Nations, 2008:2239) for high infant death rates in Brazil, drawing attention instead to the local structural determinants of health provision in Brazil, such as the political, economic and social situation. She suggests that inhumane public health practice violates bereaved mothers' rights as citizens. Characterizing a bereaved mother as 'negligent' or an accomplice to her own child's death is, she argues, "an act of interpretive violence" (2008:2239) which unjustly blames and demoralizes mother-caregivers in Northeast Brazil.

The "violence of everyday life" (Scheper-Hughes, 1993:xiii) and structural injustices underpinning women and men's reproductive lives (Aggleton and Parker, 2010; Bailey, 2011; Correa, Petchesky and Parker, 2008) have lead ethnographers to highlight the urgent need for reproductive and social justice (Unnithan, 2013; Luna and Lukar 2013; Pigg and Unnithan, 2014) across the global south. Maya Unnithan and Stacey Pigg (2014) recognise that whilst human rights frameworks increasingly inform reproductive and sexual health and wellbeing policies, planning and programmes, in the global south there is a 'growing sense' that 'reproductive justice'⁵³ has not followed from both those seeking and expecting treatment and the health professionals and development actors who work to facilitate their patients' care (2014: 1181). Their work critiques the disconnect between rights and reproductive justice (ibid), highlighting the "moralising, neo-colonial and neo-liberal tendencies implicit in international human rights frameworks" (Unnithan and Pigg, 2014; see also Brown, 2004; Zizek, 2005). Unnithan's work (2015) forefronts the value of an ethnographic approach in public health scenarios (see also Unnithan and Pigg, 2014; Bailey, 2011; Correa, Petchesky and Parker, 2008). Drawing on lived experiences of rights-based interventions in maternal, sexual, and reproductive health in India, to examine what human rights mean and how they are operationalized in healthcare

⁵³ Unnithan and Pigg (2014) employ the term 'reproductive justice' to signify contexts that are sufficiently enabled for women and men to make reproductive choices and health decisions that are meaningful and fully informed. They suggest that whereas rights are salient in a legal domain, 'justice'

contexts, she argues for a “subject-near” approach, one which entails adopting a social, cultural, interpretive, and experiential perspective (Unnithan, 2015:45). Her research highlights how understandings of rights are mediated through social and cultural lenses in India and underlines the crucial importance of “context”: defined by Unnithan as a means to situate social relationships within a specific time period (history), with regard to power (politics), and in terms of shared meaning (culture). The rights based research of ethnographers such as Unnithan and Pigg resonates in Peru and across Latin America, where I would argue, like their counterparts in India, many women have historically suffered reproductive rights violations (see Introduction; and Miranda and Yamin, 2004; Coe, 2004; Chávez and Coe, 2007; Yamin et al. 2007; Cáceres, Cueto and Palomino, 2008) and whose reproductive and maternal rights remain entangled at the intersections where unresolved and on-going debates over culture, power and reproductive justice meet. The following section will examine such debates across Latin America.

Biopolitics, ‘Stratified Reproduction’ and ‘Reproductive Governance’

A body of feminist ethnographic literature seeks to investigate the biopolitics of ‘Stratified Reproduction’ (Murray de López, 2016; Morgan and Roberts, 2012; Soto Laveaga, 2007; Goldade, 2007; Waldby and Cooper, 2008; Smith-Oka, 2003; Davis-Floyd, 1997; Ginsburg and Rapp, 1995; Colen, 1995; Lewin, 1995), a term that Shellee Colen (1995) employs to describe the ways in which certain social groups are encouraged, supported, and enabled to reproduce while others are discouraged from having children (and also Davis-Floyd and Sargent, 1997). Feminist anthropologists have shown that stratified reproduction is a common feature of reproductive politics across the Americas. In connecting large scale global influences such as neoliberalism (Ewig, 2010) with local practices and experiences, their work has shown how impoverished, indigenous and migrant women are repeatedly the main target of reproductive policies designed to limit their fertility and reproductive capacities (Murray de López, 2016; Krause and de Zordo, 2012; de Zordo, 2012; Morgan and Roberts, 2012; Ewig, 2010; Goldade, 2007). In addition, feminist scholars, influenced by Michel Foucault’s work on biopolitics, power and governance (Foucault, 1977;

more broadly engages individuals and community moralities in a wider sense, speaking to and challenging power inequalities emanating from structural injustices (2014:1181).

1979; 1991; 2012) have shown how the same women are also stigmatized for their reproductive behaviours.

Investigating how working-class black women in Brazil were offered sterilisations in exchange for the 'right' to vote, Silvia de Zordo (2012) documents how low-income participants in family planning courses reacted to the experts who viewed them as 'ignorant' as they aim to 'enlighten' them. When participants spoke about the structural challenges they faced: long and irregular work schedules; a lack of health insurance and access to expensive contraceptives; difficulties in adhering to family planning schedules – whether remembering to take the pill or the risks involved in saying 'no' to sex or insisting one's husband use a condom, experts habitually dismissed these perspectives. Seemingly unaware of structural constraints, instead the experts opted to label as 'irrational' low-income women who do not effectively use temporary contraceptives to postpone motherhood and rationally plan small families. (Krause and de Zordo, 2012:146).

Similarly, in her ethnographic work with Nicaraguan immigrants in Costa Rica, Kate Goldade (2007) shows how Costa Rican health providers practice a policy of stratified reproduction, encouraging reproduction amongst Costa Rican nationals and discouraging it amongst Nicaraguan immigrants. Her research frames the lived tension between migrant individuals seeking to access Costa Rican reproductive healthcare and the "citizen gate-keeping" strategies (2007:547) employed by receiving Costa Rican health service providers as a biopolitical process in which undocumented Nicaraguan women must negotiate reproductive strategies to gain 'cultural citizenship' over national citizenship. After Rosaldo (1994), she defines 'cultural citizenship' as how migrants "conceive of community, where they do and do not feel a sense of belonging, and how they claim rights to belong" (Rosaldo 1994:57, cited in Goldade, 2007:547). Goldade argues that obtaining 'cultural citizenship' allows Nicaraguan women to negotiate rights of access to maternal health services and protection from deportation, in addition to material gains and a sense of belonging.

In Peru, Christina Ewig (2010b) critiques historic reproductive health policies from a gender and racial based perspective in which she asserts that in areas where the population is largely indigenous, Peru's rural women have been particularly singled

out in policies and promotional campaigns which expose them to “eugenicist” imagery (2010b:153). She argues that poor women's bodies have been controlled historically as a means to achieve broader economic and social objectives (Ewig, 2010b). Similarly, in Mexico, Jenna Murray de López (2016), echoing the findings of Gabriela Soto Laveaga (2007) and Lynn Morgan and Elizabeth Roberts, (2012) argue that social programmes in Mexico have historically been used to control and curtail the sexual and reproductive behaviours of low-income populations through the direct targeting of the recipients of social programmes (see also Smith-Oka, 2009; 2013; Berry, 2013; de Zordo, 2012). Morgan and Roberts (2012) term such strategies as being examples of ‘reproductive governance’: mechanisms through which different historical configurations of actors – such as state, religious, and international financial institutions, NGOs, and social movements – use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviours and population practices (ibid). Reproductive governance is employed to dictate “standards of morality that are used to govern intimate behaviours, ethical judgements, and their public manifestations” (Morgan and Roberts 2012:242), specifically targeting women as maternal subjects, lacking rationality and responsibility when it comes to deciding their own fertility (Krause and de Zordo, 2012).

Thus across Latin America, ethnographers have shown that biopolitics operate in diverse social and cultural contexts producing tangible ‘moral regimes’ - the privileged standards of morality that are used to govern intimate behaviours, ethical judgements, and their public manifestations (Morgan and Roberts, 2012) - aimed at regulating reproductive and sexual practices as well as gender relations. Such biopolitical reproductive policies reinforce and deepen existing inequalities by targeting some individuals and groups, such as the poor, and/or immigrants, with programs aimed at controlling and limiting their fertility, while permitting others – a privileged minority – unrestricted fertility (Krause and de Zordo, 2012).

The work of Krause and de Zordo (2012), along with that of Morgan and Roberts (2012), Goldade (2007), Scheper-Hughes (1985) and others (Smith-Oka, 2009; 2013; Unnithan, 2015; Unnithan and Pigg, 2014; for example), expose the biopolitics of maternal health and maternal mortality, emphasising the need for reproductive rights and justice. Their work reveals gendered discrimination and inequality, in detailed

studies of obstetric practice, family life and the social settings within which women's lived experiences happen. Moreover the substantive perspective they offer on maternal health helps us to set individual experience in economic, social, cultural and political context. Many ethnographic studies focus on mothers' lived experiences of maternity, yet where ethnographic researchers have explicitly taken up health professionals' and traditional midwives' viewpoints, these studies are an important starting point in the context of my study (Kvernflaten, 2014; Portocarrero et al., 2015).

As we have seen, studies that deal with maternal health from a substantive viewpoint, advocate greater effort be put into intercultural healthcare with improved communication between health professionals, traditional healers and the rural populations both serve. Whilst these studies seek to collapse the dichotomy often referred to between obstetric forms of care and 'traditional' health practices, advocating medically pluralistic approaches, anthropologists addressing 'culture' from a theoretical perspective point out that there remains a tendency within health research to reify culture (Frankenberg, 1995:127; Taylor, 2007) and for health service providers to see it as a 'barrier' to be overcome in order to increase participation in and uptake of maternal healthcare provision (Gabrysch et. al. 2009; Gleit, Goldman and Rodriguez 2009; Otis and Brett 2008). Rather than recognise that culture is an evolving concept, continually created, shaped and changed by events and circumstances, biomedical researchers and epidemiologists tend to reduce culture to a series of traits, only serving to homogenize large groups of loosely connected individuals (Kierans, 2016; Kierans and Cooper, 2011), assumptions that are nevertheless built into health promotion and policy (Kierans, 2016). In situations where population groups become defined by cultural traits, they can also become culturally defined 'risk' groups; identified, surveilled and regulated in relation to their health (Abu-Lughod, 199:149; and also Kierans, 2016:24).

Kierans' work offers an alternative understanding of culture, positioning it as the outcome of social processes and practices (Kierans, 2016: 24): a resource put to work by the ethnographer's informants in the course of their everyday lives. Her stance stands in stark contrast to the current way in which Peru's Ministry of Health positions culture: as a determinant of health, static and unchanging and a barrier to be overcome in the provision of maternal healthcare in the Andes region.

As a final point, the contested nature of the culture concept is well documented across the anthropological literature⁵⁴, and has long been the subject of intense debate and dialogue. With so many definitions of what constitutes culture, a unified perspective across the anthropological literature cannot be assumed. However, the work of anthropologist Michael Agar (2006) offers us a useful way of working with the cultural concept in practice. Agar advocates an understanding of culture as an artificial construction, to be used as a translation mechanism between the ethnographer and the person or persons studied. Used in this way, culture thus becomes an ethnographic lens that allows us to focus upon different meanings and sense making practices that emerge amongst the persons studied, and the contexts in which such meanings are embedded. As the ethnographic literature I have reviewed above shows us, if we want to engage with the everyday lives and lived maternal health experiences of women as they are played out in practice, rather than assuming culture to be a static trait, we must instead examine it within the overlapping contexts of political economy, and the social worlds that create it. In so doing, ethnographic research allows us to see that maternal health and MMR are not only a problem for medicine, but expand beyond the obstetric domain in various ways, that can only be discovered through fieldwork that takes maternal health in practice and situated context as its primary focus. If we want to understand these practices as they are lived out in context, we need to follow them in the field.

Conclusion

In documenting the spread and depth of Peru's maternal mortality problem, the epidemiological literature reviewed in this chapter presents high maternal mortality ratios (MMR) as a particular problem amongst rural Andean populations, living in remote geographical areas where access to health services is difficult (Alcala and de la Galvez-Murillo, 1994; Chirinos, Sobrevilla and Alcantara, 1994; Becerra et al., 1998; Alcalde-Rabanal, Lazo-Gonzalez and Nigenda, 2011). MMR is pertinent to certain categories of patients within these geographical areas – defined by ethnicity, educational level, socio-economic status and compounded by cultural factors (Parodi, 2005; Benavides, 2005; Caballero et al., 2010). Unequal coverage affects women

⁵⁴ For an overview of the changing nature of the culture concept and its use in medical anthropological discourse, see Ciara Kierans' chapter "Culture", in *Social and Cultural Perspectives on Health*,

attempting to access maternal health provision through the government's SIS health insurance programme: the extension of health insurance to include impoverished populations without the financial means to access primary health services is an on going challenge for the Ministry of Health in Peru (Arce, 2009; Ugarte Ubilluz 2009; Wilson, Velasquez and Ponce, 2009; Alcalde-Rabanal, Lazo-Gonzalez and Nigenda, 2011).

The health and social policy literatures reviewed document how Peru's Ministry of Health has introduced a series of policy measures specific to the Andean region, which mobilise 'culture' to encourage rural Andean women to forego their preference for home birth and agree to clinically managed birth, (Salaverry, 2010; Arce 2009; Knipper 2010; Ugarte Ubilluz 2009) further incentivising them to do so by the introduction of cash conditionality programmes (Arrospide, 2009; Diaz et al. 2009; Perova and Vakis, 2009a; 2009b; Arroyo, 2010a; 2010b; Vargas Valente, 2010; Guzmán and Bethsabe, 2013; Perez Lu, 2016). Policy studies necessarily focus upon the structural and systemic difficulties encountered in providing maternal healthcare, flagging up shortfalls in service provision to be addressed (MINSA 1999; Loayza Condori 2003; Calisaya 2004; MINSA 1999; CARE 2007) or promoting improvements in quality of care for patients accessing services through the implementation of new policy measures (Salaverry, 2010; Arce 2009; Knipper 2010; Ugarte Ubilluz 2009). Independent research, commissioned outside of the government domain is limited, but where it has been carried out, health and social policy researchers also highlight systemic inequitable access to maternal health services (PHR, 2007; Fraser 2008; Camacho, Castro and Kaufman 2009; Bristol, 2009; Knipper 2010), discriminatory attitudes of health personal towards patients (Kayongo et al, 2006) and 'cultural barriers' to obtaining empathetic care (Kayongo et al., 2006; Tarqui-Mamani & Barreda-Gallegos 2006; Bristol, 2009; Callister 2009; Amnesty International 2009; in Zug 2013).

A review of the qualitative health literature situates maternal health from an experiential viewpoint. The applied perspective of these studies, emerging from the fields of nursing and sociology, necessarily situate qualitative health research taking place within health establishments. We learn that despite attempts to incorporate

intercultural health initiatives into maternal health provision, discrepancies in views and experiences are expressed amongst health professionals, traditional practitioners and patients utilising services. Practitioners feel a lack of education, training, and inadequate health infrastructures hamper their work (Mayca et al. 2009; Rodriguez Honorio, 2015; Sumeriski, 2016), and patients and midwives cite lack of respect, failure to adequately consult with patients and involve them in their healthcare decisions as factors limiting the successful translation of intercultural medicine policies into clinical practice (Valenzuela Ore et al., 2015; Sumeriski, 2016). However, with clinical spaces as the starting point for these studies, we do not learn about the experiences of the uninsured women who do not have access to government healthcare, or the opinions of women who choose to forego state provided intercultural healthcare and clinically managed birth, opting to give birth at home instead. There remains a critical need to examine these women's perspectives and experiences of maternal health provision in the Andes today.

A wide body of ethnographic literature drawn from across Latin America situates maternal health and maternal mortality as lived experience embedded in socio-cultural and structural context. Ethnographers show us that for many women in Latin America and across the global south, biopolitical processes seek to govern, monitor and ultimately control their reproductive capacities. Impoverished indigenous and migrant women in particular succumb to targetted reproductive policies designed to limit or curtail their fertility (Murray de López, 2016; Krause and de Zordo, 2012; de Zordo, 2012; Morgan and Roberts, 2012; Ewig, 2010; Goldade, 2007). In addition large-scale social forces such as poverty, unemployment, political violence and war, racism and gender inequality (Farmer et al., 2006) determine who has access to care and who does not. Such continued inequities have lead to calls for social and reproductive justice from ethnographers working within the domains of reproductive and maternal health (Unnithan, 2013; Luna and Lukar 2013; Unnithan and Pigg, 2014).

Ethnography further emphasises that for many women in Latin America, generalised policies pertaining to maternal health provision do not always meet their needs when they are applied in local cultural contexts (Berry, 2005; Portocarrero et al. 2015), nor do women always make the choices that fit the worldviews of their caregivers, health

planners, or the state-supported medical system that organizes the possibilities available to them (Davis-Floyd, Pigg and Cosminsky, 2001). The changing status of the work of the lay midwife in diverse settings and different countries of Latin America attests to this. Marginalised and her role redefined in Nicaragua (Kvernflaten, 2013), required to adapt her practices in line with modern, obstetric practice in Guatemala (Berry, 2005), currently unrecognised and officially forbidden to practice in Peru (Portocarrero et al., 2015) ethnographers show us that lay midwives nevertheless continue to meet the biosocial and cultural needs of indigenous women (Murray de López, 2016), exposing the gaps in understanding of policy makers (Standing, Oronje, and Hawkins, 2011).

The findings discussed in this chapter have orientated the rationale for my study and exposed areas that merit further research. There is very little recent ethnographic research in Peru that explicitly focuses upon maternal health provision and access in light of policy changes introduced post 2009, with the introduction of the Sexual and Reproductive Health Strategy. As I have documented, much public health research is government funded within Peru and shares commonalities in seeking to examine policy initiatives with a view to improving patient access and experience, whilst simultaneously promoting Ministry of Health strategies. My research articulates the perspectives and practices of the social actors involved, ethnographically examining maternal health and the intercultural initiatives accompanying it ‘from below’; that is, from the perspectives and experiences of the women who access it via the government’s SIS health insurance and the practitioners charged with providing their care. Further, I have widened the focus of my study to include the lived experiences of rural women who are uninsured, or in rejecting government calls to deliver in state run clinics, continue to seek out alternative solutions to their maternity.

In conclusion this chapter also sets up a discussion of my methodological orientation. The epidemiological, policy and qualitative health literatures reviewed here provide a partial view of maternal health, but I have chosen to adopt an ethnographic perspective in my study in order to contextualise maternal health within a much broader cultural and political economic perspective. One of the things that differentiates the ethnographic perspective from the others examined here is that it does not seek to define maternal health and MMR in particular ways (as, for example,

a matter of epidemiological, structural or experiential significance) but rather seeks to find out what comes to define maternal health and MMR in the contexts being studied. In this way, I seek to discover what really matters for rural women and practitioners as maternal health is accessed and delivered across the Peruvian Andes today. The following chapter documents what was involved and how I went about achieving this.

Chapter Two: Methods and methodology

Introduction

This chapter outlines the ethnographic approach that I undertook to carry out my study on maternal health in the Peruvian Andes. Having examined the literature around maternal health in the previous chapter, I have concluded that a wider perspective needs to be taken when considering pregnancy, birth and maternal mortality ratios across Andean regions. My perspective does not position ‘culture’ as a determinant of maternal health outcomes, nor as a tangible concept to be invoked in the managing of rural, impoverished women’s maternity as Peru’s Ministry of Health, and much previous research, policy and health promotion interventions have done across the Andes’ regions. Rather, following Agar (2006), in this thesis where I draw on culture, I do so as a ‘translation mechanism’ (Agar, 2006) to assist in better understanding the maternal health ‘problem’ as it is currently understood and experienced by women in the Andes today. To gain a deeper ethnographic understanding, I have elected to observe the various people, institutional procedures, and their practices, objects and settings related to maternal health provision and access. To this end, my research focuses on the maternal health encounter, and the structural issues shaping it, as detailed below.

Research aim

The aim of this study is to understand maternal health encounters in the context of current healthcare policy in Peru. Specifically, I document the practices and experiences of rural Andean women and their families, eligible to access maternal healthcare via the Ministry of Health provided integrated health insurance, SIS (*Seguro Integral de Salud*). In meeting this aim my objectives are to;

- Document and examine the maternal healthcare encounters of rural Andean women accessing maternal health provision from confirmation of pregnancy through to birth and *post partum* care.
- Identify and examine the networks and resources women and their families draw on during pregnancy, birth and postnatal care.

- Understand how health providers, families, and communities engage in the care of the *gestante* (pregnant woman).
- Examine how maternal health policy objectives are understood, implemented and received in rural locations.
- Explore the social, political and economic contexts shaping Andean women's experiences of maternal healthcare.

In focussing on the maternal health encounter between pregnant women and healthcare providers, patients and practitioners guided me to the range of issues at stake and relevant for them.

Ethnography as a research method

In order to meet the aims and objectives of this study, I have conducted this research ethnographically. The aim of ethnographic research, as understood within the anthropological and sociological tradition, is to generate an understanding of the social world of people through immersion in their community and ways of living to produce a detailed description of them (Ritchie and Lewis, 2003:12). This is achieved through an in depth study of their everyday life, routines, interactions, practices, and shared meanings (Wacquant, 2003). Physical space, actors, objects, actions, events, time sequencing, goals and feelings may all be examined (Spradley, 1980) to uncover the complexities of everyday life. How these details interact with wider socio-political, economic and cultural contexts, transforming people's understandings is also an important aspect of ethnographic research, what Joao Biehl and Adriana Petryna term the "entanglements between systems and human experiences" (2013:13). In addition, ethnography also allows us to discover "the gaps in the gaze" (Gibson, 2004): that is, ethnography provides opportunities to gather empirical insights into social practices that are normally "hidden" from public view (Reeves, Kuper and Hodges, 2008:514). In so doing, ethnography is flexible in nature (Holloway and Todres, 2003), as data are examined to identify and to categorise themes and key issues that "emerge" as the study progresses (Reeves, Kuper and Hodges, 2008:513). An ethnographic stance then, requires a level of flexibility from the researcher. (S)he must become on the one hand, able to change direction when study findings challenge previous assumptions (Pigg, 2013) and on the other, she

must become what George Marcus terms a “circumstantial activist” (1995:95), a reflective persona able to adapt to the changing circumstances, settings and identities encountered in multi-sited ethnography.

In recent years, global health has emerged as a key concern (Farmer et al., 2013; Pigg, 2013; Biehl and Petryna, 2013), and health interventions have increasingly reflected a focus on international cooperation and intervention (Biehl and Petryna, 2013:6). In terms of maternal health, the Millennium Development Goals (MDGs) have been instrumental in driving forward health initiatives designed to reduce MMR across the global south. Ethnographic research has reflected such change, examining the outcomes of global maternal health initiatives and the lived experiences of maternity in cross-cultural contexts (Kvernflaten, 2013; Smith-Oka, 2013; Berry, 2013; Purnell 2012; Davis-Floyd, Pigg and Cosminsky, 2001; Davis-Floyd and Sargent, 1997; De Vries et al. 2002). The anthropological research reviewed in the last chapter, which takes cross-cultural perspectives on maternal health as its main focus, is a good example of this shift in emphasis.

An ethnographic approach thus lends itself to a study of maternal health encounters, allowing us to examine the lived experiences of maternity, as lives lived play out in practice and in local context. As Nancy Scheper Hughes emphasises, ethnography permits both the researcher and the reader to be drawn into particular “spaces of human life” through the “act of witnessing” (1992:xii). Whilst reading, reflecting and writing are key to the ethnographic approach (Scheper Hughes, 1992:xiii), the lives lived through the stories told are for me the essence of ethnography. Andean women’s childbirth stories then are central to the understandings gained through the writing of this thesis.

Further, by bringing an ethnographic orientation to bear on current maternal health policy, I seek to make visible the myriad interwoven factors impacting on maternal mortality ratios (MMR) and maternal health. In so doing, I provide a contextualised and nuanced description and analysis of how MMR and maternal health is played out in practice from confirmation of pregnancy through to birth and postnatal care. Seen from an ethnographic perspective, the problems that accompany maternal health and MMR cannot exist discretely; they are, instead, socially, culturally, politically and economically embedded phenomena. In order to fully grasp their significance, the

particular local context in which they occur must therefore also be taken into account; in this case the Andes region of Peru. Given the difficult geography of the region, maternal health in Peru is practiced across a number of diverse and often geographically distant sites: the hospital, the consultation room, the delivery suite, the local *Posta de Salud* (the health outpost), the home, and within the wider community. As a result, a study of maternal health in the Andes will need to examine those different sites, as it is here, in homes, consultation rooms, hospitals and community, that maternal health acquires its particular social meanings. As Jane Ritchie and Jane Lewis (2003) underline, carrying out research across different settings allows the ethnographic researcher to explore the interaction between phenomena occurring in differing contexts. Different settings also influence how the research issue is experienced (2003:51).

Theoretical Perspective

My study perspective has been influenced by the published literature on political economy, biopolitics, and obstetric and structural violence (Lemke, 2011; Foucault, 1990, 2003; Farmer, 1996). As a study of maternal health in the Peruvian Andes will necessarily lead me to the very specific and local settings within which maternal health policy is delivered, - locations far removed from the policy maker's office - maternal health must also therefore be viewed as part of the wider political picture within which it is embedded. "Physicians for Health" (2007) have documented how Andean populations have historically been marginalised and discriminated against in reproductive health policy (Miranda and Yamin, 2004; Coe, 2004; Chávez and Coe, 2007; Yamin et al. 2007; Cáceres, Cueto and Palomino, 2008) and continue to be so today. The structural injustices underpinning women and men's reproductive lives (Aggleton and Parker, 2010; Bailey, 2011; Correa, Petchesky and Parker, 2008) and the pressing need for social justice in reproductive health fore fronted by Maya Unnithan amongst others (Unnithan, 2013; Luna and Lukar 2013; Pigg and Unnithan, 2014) are well documented across the anthropological literature and are a starting point for my study. In undertaking an ethnographic study of Andean women's maternal health, I am conscious that many Andean women were subjected to enforced sterilisations under the Fujimori regime (Miranda and Yamin, 2004; Coe, 2004; Chávez and Coe, 2007; Yamin et al. 2007; Cáceres, Cueto and Palomino, 2008), a

reproductive health issue that remains unresolved and continues to generate discussion, division and political controversy in Peru today (Getgen Kestenbaum, 2008; Pieper Mooney, 2010; Pegram, 2011). As Nancy Scheper Hughes underlines, the ethnographer, in carrying out her research, is granted the possibility of viewing her study participant's stories "through a glass darkly" (1993:xiii), as ethnography can often reveal uncomfortable or difficult realities, what she terms "the violence of everyday life". I am conscious therefore, that in investigating maternal health understandings and experiences amongst Andean women, I must be sensitive to the historical and political contexts into which Andean women's reproductive health experiences are embedded and whose effects are embodied in their narratives and reproductive health decisions. Paul Farmer's work on structural violence (Farmer, 1996; Farmer et al., 2004), showing how wider structural issues impact upon the lives and health of the poor negatively affecting their health outcomes, also resonates strongly with me, linking with my personal observations when I lived and worked in the Peruvian Andes prior to undertaking this study. Therefore, when listening to Andean women's narratives of pregnancy and birth, I also consider the social and political situation in which the mothers-to-be find themselves. Socio-economic standing and geographical location are central to Andean women's reproductive health experiences, shaping women's experience of pregnancy and childbirth and the healthcare received. In Peru, the manner in which healthcare is accessed is determined by the political-economic situation of people: all of the participants in my study were eligible to access maternal health via the government sponsored SIS (*Seguro Integral de Salud*) or Integral Health Insurance, eligibility for which is determined directly by virtue of low socio-economic standing or impoverishment (Kristiansson et al. 2009; Francke, 2013; Petrera et al. 2013).

Fieldwork and field sites: Chiara and Izcuchaca

To carry out my ethnographic research, I conducted fieldwork across two sites: the *comunidad campesina* (rural community) of Chiara, in the highland Apurimac region of Peru, served by a *Posta de Salud*; and the town of Izcuchaca in Anta province, providing maternal healthcare from a centrally located clinic serving seven rural communities in the surrounding area. I carried out fieldwork over three separate

extended visits: from October to December 2010, October to December 2011, and June to September 2012 respectively.

I chose my field sites based on the high MMR evidenced in the epidemiological literature across the Andean regions⁵⁵, the particular significance of maternal health as a problem for State insured patients accessing healthcare provision in the region,⁵⁶ personal invitation⁵⁷, as well as my familiarity with the Province of Cusco, in which Izcuchaca is located, having lived there for two years and being a repeated visitor to the Andean region each year. In the following section I describe the field sites, the data collection strategies employed and the participants in this study.

The 'comunidad campesina' and district of Chiara

Chiara is designated a *comunidad campesina* (rural community)⁵⁸ and is situated within the larger district of Chiara, one of 19 districts, which together make up the Province of Andahuaylas, part of the larger Department of Apurimac (Figure 9). The *comunidad campesina* of Chiara has existed for several centuries (Castillo, Fernandez et al., 2014) and Chiara, as an officially recognised political district came into being on 5th April 1935 when Law 8073 was passed during the second term in office of President Antonio Benavides (Government of Peru, 2017). Historically, the district was a centre for copper mining, remains of which can still be found today. The district of Chiara covers an area of 148.92 km² and situated at 3,270 metres above sea level, is composed of the district capital, the rural community⁵⁹ of Chiara, where I carried out my field research, and three neighbouring hamlets: Nueva Huillcayua, Santiago de Yaurecc and Huanipa Chilmay. In 2007, government estimates place the population of the community of Chiara at 1342 (INEI, 2007). The *chiarinos* (residents of Chiara) speak Quechua as their first language, although many of the younger inhabitants are

⁵⁶ As discussed in the literature review, researchers have reported profound inequities in access to and outcomes of maternal health provision in populations of low economic status in highland populations, particularly across the Andean provinces of Apurimac and Cusco (Watannabe 2002; PHR 2007; Fraser 2008).

⁵⁷ Claudio Chipana, a close friend of mine living in London, suggested I carried out research in his rural community, Chiara, and was instrumental in paving the way for me to do this, obtaining the permission of the local village authorities for me to stay and research in the village.

⁵⁸ It is estimated that there are 5680 *comunidades campesinas* in Peru according to a National Agricultural Survey of 1994 (Castillo Fernandez et al., 2014).

⁵⁹ In my conversations with the *chiarinos*, residents of Chiara, they would always refer to their village as a *comunidad campesina* (rural community). Throughout the thesis, when I refer to 'the community' I do so reflecting the *chiarinos* own sense of the word.

able to converse, read and write in Spanish too, largely due to the influence of the Primary and Secondary Schools in the village. However, older residents generally speak Quechua only and I observed that illiteracy remains high amongst them.

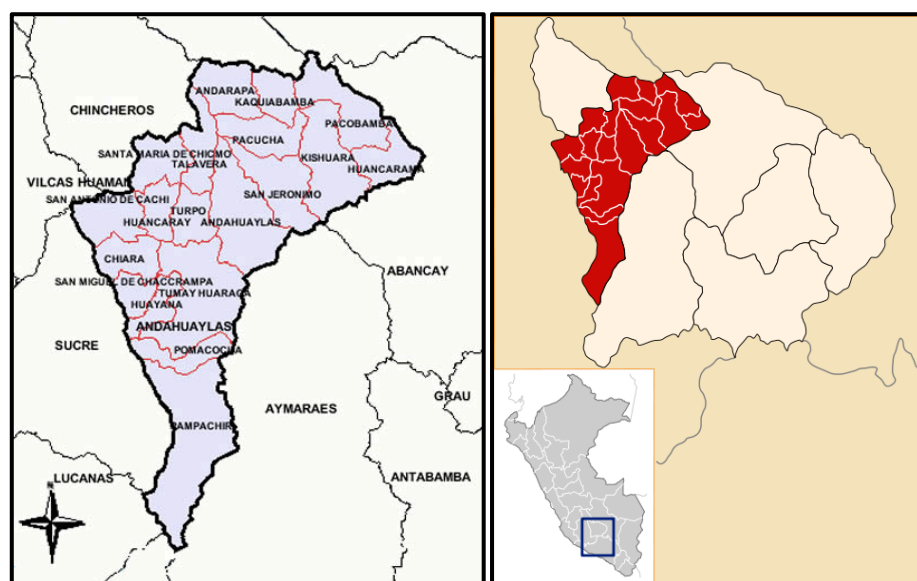


Figure 9: Maps showing location of Chiara and Huancaray, within Apurimac Province and geographical location of Apurimac within the Republic of Peru.

Source: Source: map-peru.com

The majority of residents live in simple one or two storied *adobe* (mud brick) houses, and it is common for the extended family to live together (Figure 10). Chlorinated running water is provided to most houses via a standpipe located on the patio outside the house and basic latrines are also located outside of the living quarters. Cooking is done by building a fire and burning wood, cut from the eucalyptus trees surrounding the village. Due to lack of employment in the area, many of Chiara’s residents are seasonal visitors, living in Callao, Lima and returning to the village only to assist with sowing, reaping and harvesting of crops. Residents of Chiara who have relatives in Lima, or who operate one of the local stores in the village, generally enjoy an improved standard of living, evidenced by the ‘home improvements’ they make: they may construct houses from what the *chiarinos* refer to as *material noble* - “noble materials” - which include brick, cement, steel or glass. Such houses are regarded as symbols of modernity and advancement and are over time also equipped with luxury

white goods such as gas stoves and fridges, although these remain in very short supply in Chiara⁶⁰.



Figure 10: Adobe houses line Chiara's main street. The concrete flat roof in the foreground (bottom right of frame) is the *Posta de Salud*, the flat roofed building amongst the tiled houses is the *Club de Madres* (Mother's Club).

Figure 11: The *chacra*: communal and familial plots used for agriculture surround the village.

Residents who live year round in Chiara are employed in the majority in agriculture, with each family carefully tending to their livestock: cattle, goats, pigs, chickens and *cuyes* (guinea pigs). Each family also has a plot of land or *chacra*, which provides the mainstay of the *chiarinos*' diet: quinoa, potatoes and other root vegetables, beets and alfafa (Figure 11). The *chiarinos* only grow enough food for their own family's consumption. Fruit, other vegetables and foodstuffs are in limited supply in the few local stores operating out of the front rooms of the more entrepreneurial-minded residents' houses. Alternatively, essentials must be purchased on market day in the regional capital of Andahuaylas, a five-hour journey along torturous mountain earth roads by *combi*; the local and infrequent minibus service connecting Chiara to the capital. Andahuaylas is the administrative centre for *chiarinos* and their nearest port of call in a medical emergency: the Regional Hospital is located here, although there is a smaller clinic located two and a half hours drive away in the village of Huancaray. Primary healthcare needs, including maternal health antenatal care⁶¹, are

⁶⁰ I saw gas cookers, fridges and the only television in the village in the living quarters of the *Posta* staff. An elderly couple living in a concrete and brick house opposite the *Posta*, whose son was a journalist in Lima, also had a gas cooker as did the shopkeeper who ran the largest store at the southern end of the village.

⁶¹ Although antenatal scans are not provided in the *Posta*, *chiarinas* must travel to Huancaray to access this service.

provided for at the *Posta de Salud*, the health outpost located at the entrance to the village when arriving from Andahuaylas by *combi* (Figure 12). During my field research, one newly qualified Spanish speaking Doctor, one bilingual Quechua and Spanish speaking Obstetrician, and two nurses – one of whom spoke Quechua, and one who did not, worked at the *Posta*. Healthcare is provided under the State's social security programme: all *chiarinos* are enrolled in the SIS – *Seguro Integral de Salud* – Integral Health Insurance programme. Designated a region of extreme poverty, Chiara also qualifies for inclusion in the state-funded social development programme *Juntos*, the conditionalities of which I discussed in Chapter 1.



Figure 12: Children sheltering from the hail outside the *Posta de Salud*, Chiara. The multi-paned window on the left is my accommodation during my first period of field research.

Izcuchaca, District of Anta

Izcuchaca, the second municipality where I conducted fieldwork, is very different to Chiara. Izcuchaca is a bustling, industrialised town located at 3,508 metres above sea level and some 17 km from the number one tourist destination in Peru: the town of Cusco. Izcuchaca is the capital of the District of Anta, one of nine districts comprising the wider Department of Cusco (Figure 13). The Peruvian government created the District of Anta on 19th November 1839. The District of Anta has a population of 56,638 inhabitants according to data from a 2014 survey (INEI, 2014). The principal industry in the Anta District is the Yura fertilizer factory in Cachimayo, producing fertilizer, nitrates and other derivatives for the Cusco region. Residents of Izcuchaca work in local businesses, schools or in the tourist industry in Cusco. The town is well connected with fleets of buses, *combis* and *stations* – shared taxis, regularly leaving for Cusco and its environs every few minutes.

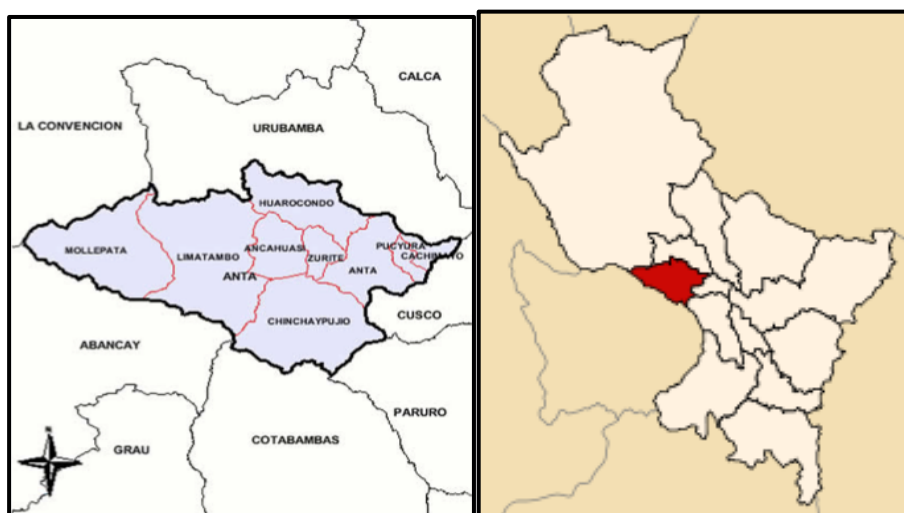


Figure 13: Maps showing the location of Anta district capital (left). Izcuchaca is located within its borders. Anta District within the Province of Cusco (right). Source: map-peru.com

The town of Izcuchaca with its congested main street – a messy conglomeration of cement and brick store fronts - is a busy intersection of roads and rail, ferrying local inhabitants and visitors from outlying rural communities to and from the daily indoor food market, the local hardware stores selling all manner of building materials and the local administrative businesses such as lawyers, which abound. The ‘*rieles de Anta*’ – the locals’ name for the railway tracks which run, unprotected, straight past the doors of the CLAS⁶² Anta, the town’s Health Clinic, regularly transport tourist clientele straight through the town and on and up into the high reaches of the Andes en route to Peru’s most famous tourist destination, Machu Picchu. The trains do not stop in Anta, and it is a regular occurrence at the clinic to have to attend to injured drunks stepping across the lines who failed to see or hear the tourist train approaching. The only asphalted road in Izcuchaca is the main road from Cusco, elsewhere, roads are earth, beyond the centre of town pavements cease to exist and the concrete store fronts quickly give way to the familiar humble brown mud brick facades and red tiled roofs of typical Andean highland houses and semi-rural open highland spaces (Figure 14).

⁶² CLAS stands for *Comunidades Locales en Administración de Salud* (Local Community Health Administrations). Set up in 1994 by MINSA, as part of the PAC initiative (*Programa de Administración Compartida*: Shared Administration Programme) the objective is to devolve local administration of healthcare to the communities they serve in an attempt to improve the efficiency of healthcare spending, the quality of services and equity of access. The success or failure of the CLAS is an ongoing subject of debate across the public health literature. See Cabrera Arredondo, 2004; Altobelli, 1998a; 1998b; 2008; Altobelli and Acosta-Saal 2011; Ewig, 2002.



Figure 14: Semi rural scene on the outskirts of Izcuchaca. The fenced in area to the left is a community sports area and Ausangate, the highest mountain in the Cusco region, can be seen shrouded in clouds.

The CLAS, referred to locally as the “Hospital”, is the central referral point for patients in Izcuchaca and its outlying rural communities (Figure 15). Patients are sent here from the *Postas de Salud* for dental, paediatric and maternal care and medical emergencies. *Obstetricia*, the Obstetric department, runs family planning consultations, antenatal check ups, including foetal monitoring: although antenatal scans must be carried out in one of the two regional hospitals in Cusco: the Antonio Lorena or the Hospital Regional. The clinic has a delivery suite and a maternity ward with a limited number of beds. Routine vaginal deliveries take place here, caesarean or emergency births are referred on to the hospitals in Cusco. *Obstetricia* is staffed by a team of six obstetricians, all female bar the lead obstetrician Enrique, who was also the Director of the Clinic at the time of my field research. Only two of the obstetricians were native Quechua speakers.



Figure 15: Centro de Salud CLAS Anta, referred to by locals as the “hospital” in Izcuchaca.

Other than the CLAS, there are a number of private healthcare enterprises in operation in Izcuchaca. One such private clinic has been built and is run by one of the doctors working for the Ministry of Health in the CLAS. Private companies offer antenatal scans ‘on the spot’ and contraception is readily available at a price in the many branches of the different pharmacies that abound in Peru. Thus, patients in Izcuchaca, in contrast to those in Chiara, have a range of healthcare options readily available to them, not to mention the vast range of health clinics available some 40 minutes drive away in Cusco: ranging from MINSA run clinics through to 5 star tourist hospitals resembling hotels rather than health establishments. However, whilst Izcuchaca itself is a modern, expanding town, it is important to underline that many of the patients who attend the CLAS do so from outlying rural communities. Thus, similar to the *chiarinos*, they live in impoverished conditions and are tied to the services provided by the state, by virtue of their low socio-economic status. Whilst patients who attend the CLAS are obligatorily enrolled in the SIS, the state funded health insurance scheme, many who would qualify for the scheme do not enrol and are thus uninsured. Further, by virtue of its location in Cusco Province, Izcuchaca is not classified as an area of extreme poverty. Residents are thus unable to participate in social development programmes like *Juntos*, which do not run in the area, in stark contrast to Chiara, where all residents are enrolled in *Juntos* and access healthcare through the SIS insurance scheme.

Ethnographic observation and participation

To conduct fieldwork in Chiara I was initially housed in the *Posta de Salud* from where I was able to observe clinical practice on a daily basis. In addition, when the *Posta* was quiet or closed, I spent a lot of time visiting the *chiarinos* I had befriended in their homes. To integrate more fully in village life, and recognising the importance of reciprocity in carrying out fieldwork (Ritchie and Lewis, 2003:64) I also attended community meetings, participated where possible in shared work and communal responsibilities, and by virtue of my profession as a teacher in the UK, I also assisted often in the local primary school teaching classes in conjunction with the local teachers. This activity, in particular, allowed me to get to know the mothers of the young children in the village as they dropped their children off at school and collected them again at lunchtime. As I was a friend of Claudio's – whose charitable work in London financially supported the local *Club de Madres* – the Mother's Club – I spent considerable time with them, helping them prepare food for the older residents of the village. In this way, chatting to the women and observing and taking part in their daily routines, I gained valuable insight into the lives of the women living in Chiara, aspects of which I discuss in Chapter 3.

After spending two periods of research at the *Posta de Salud* in Chiara, I decided I needed to carry out fieldwork at the referral hospital where women gave birth in order to advance my research, as births are prohibited in health outposts (as I will discuss in more detail in Chapter 3). However, a series of events occurring in Chiara, made it not only extremely difficult for me to continue with my research there, but also to gain access to the referral clinic at Huancaray. In 2011, when I returned to Chiara for the second time, the team of health professionals working at the *Posta* had changed. During my initial visit, largely thanks to Claudio's connections in the village, I had been made extremely welcome at the *Posta* by the health staff who had been more than happy for me to observe clinical practice. However, this time around, the new doctor in residence, made it quite clear to me that my presence was not only not required, but was also unwelcome. Where previously I had resided in the *Posta*, thus being present twenty-four hours a day, this time the doctor and the new nurse would not permit me to do so. Consequently I had to move out almost upon arrival and I took up residence with a woman I had befriended the year before, whose husband had recently been elected Mayor. The Mayor kindly agreed to let me camp out in his

office. Aside from the 3am early morning calls from residents of Chiara who regularly called at the office on their way to their *chacra* (cultivated plot of land) to discuss community matters with the Mayor, this arrangement proved to be fruitful in leading my research in a new direction. Initially worried that, now the doors of the *Posta* had effectively been closed to me, I would not be able to advance my research as my access to the health professionals had been severed, I soon discovered an unexpected twist. The community women, who had been extremely kind to me the previous year, regularly coming to the *Posta* to deliver me a bowl of soup or a plate of rice and vegetables for lunch, were indignant that I had been asked to move out of the *Posta*. Many of these women, friends of Claudio and supported by the charitable works he carried out from London, began to talk to me much more openly about their maternal health experiences now that I was living in the Mayor's house, rather than in the health outpost. I was thus able to gain much deeper insight into the women's experiences and opinions around maternal health in Chiara than previously. That said, it soon became clear that unless I could access a higher level clinic, where births actually took place, I would not be able to fully understand the maternal health picture the women were painting for me. Thus, I contacted Dr. Grover, a physician that I knew well in Cusco, having been a patient of his during the time I lived in Cusco, and he introduced me to Janeth, an obstetrician working in the CLAS in Izcuchaca.

Gaining access to a higher-level clinic⁶³, one where deliveries took place, allowed me to observe obstetric practice and clinically managed birth directly. Further, I was able to interview a team of specialist obstetricians and doctors, with many years of experience working in the clinic. Such observations and what I learnt about the structure of the clinic and the working conditions for the health professionals employed there, form the basis of Chapter 6. Janeth, in particular, was interested in my study and provided me with opportunities to chat with patients, quickly becoming my key informant in Izcuchaca. She would often flag up 'interesting cases' for me, ensuring I got to sit in on patient consultations and she was instrumental in encouraging *gestantes* and new mothers to talk to me once their consultation had ended. She also invited me to accompany her on her round of Home Visits. In this

⁶³ Ministry of Health clinics are classified from 1-4. A level 1 classification denotes a *Posta de Salud* such as the one in Chiara. A fully functioning Hospital with operating theatres, is a Level 4 (for example the Hospital Regional or the Antonio Lorena Hospital in Cusco). CLAS Anta was classified as a Level 3 clinic, offering three specialisms: obstetrics, pediatrics and dentistry.

way she furthered my understanding of maternal health practices by opening new avenues of investigation resulting from my conversations with a wider range of patients across different settings. The results of such home visits and conversations are discussed in Chapters 5 and 7.

Participants and cases

In ethnographic or field studies, sampling is required simply because the researcher cannot observe or record everything that occurs (Burgess, 1982a; Hammersley and Atkinson, 1995). Research participants may be selected because they have particular features or characteristics which enable detailed exploration of the themes and puzzles the researcher wishes to study (Ritchie and Lewis, 2003:78), relating to socio-demographic characteristics or specific experiences. Accordingly, my research participants were selected not only because they lived in Chiara or attended the clinic in Izcuchaca, but also because they had recently experienced maternal health provision as currently practiced in the Andes. I was primarily interested in patients who were either pregnant or had given birth subsequent to the shift in institutionalised birth in Andean regions from 2009 onwards, whether their previous births had been in the clinic or at home with the assistance of a *partera* and/or family members, and how the women felt their birth experiences compared. By the end of fieldwork, I had collected the stories of 16 such women from the same number of families (Figures 16 and 17).

Pseudonym/Age	Date of Last Pregnancy	Place and Type of Delivery	Total No. Of Children	No. Of Surviving Children
Milagros, 27	2009	Clinic Huancaray (VB)	2 (1 home birth: 2000)	2
Rosalinda, 43	2010 (current)	Posta – Chiara (VB)	9 (8 previous home births)	9
Elena, 35	2009	Hospital Andahuaylas (VB)	2 (1 home birth: 2000)	2
Isabela, 34	2009	Clinic Huancaray (VB)	5 (4 home births)	5
Marcelina, 28	2009	Clinic Huancaray (VB)	2 (1 home birth: 2006)	2
Nati, 39	2011 (current)	-	3 (1 home birth: 1994; 1 miscarriage: 2010)	1
Patricia, 16	2009	Hospital Andahuaylas (VB)	1	1
Lucrecia, 23	2009	Clinic Huancaray (VB)	1	1

Notes: Age at time of first interview. ‘Current’ denotes that the woman in question was pregnant at the time of my field research. VB=vaginal birth. EC= Emergency Caesarean.

Figure 16: Case Studies in Chiara

Pseudonym/Age	Date of Last Pregnancy	Place and Type of Delivery	Total No. Of Children	Number of Surviving Children
Violeta, 25	2012 (current)	Hospital Cusco (EC)	4 (4 clinic)	4
Jessamyne, 21	2012 (current)	-	0	1 st pregnancy (ongoing)
Rosa, 17	2012 (current)	CLAS Anta (VB)	0	1 st pregnancy
Yesica, 17	2012 (current)	Hospital Cusco (VB)	0	0 (baby died)
Nancy, 22	2012 (current)	CLAS Anta (VB)	0	1 st pregnancy
Emperatriz, 25	2011	Hospital Cusco (VB)	2 (Home birth: 2008)	2
Silveria, 24	2012 (current)	Hospital Cusco (EC)	0	1 st pregnancy
Flora	2012 (current)	CLAS Anta (VB)	5 (Home births)	5

Notes: Age at time of first interview. ‘Current’ denotes that the woman in question was pregnant at the time of my field research. VB=vaginal birth. EC= Emergency Caesarean.

Figure 17: Case Studies in Izcuchaca

I visited all of the *gestantes* from Chiara who participated in the study in their homes, and as many as possible from Izcuchaca⁶⁴, to interview them and their respective family members, but also to observe and understand how being pregnant impacted upon their everyday life and daily routine. These visits served to develop our research relationship (Ritchie and Lewis, 2003), building rapport with the *gestantes* and their family members and facilitated further introductions to many other women in the communities who had had children. As I got to know the women better, they allowed me to take photographs of their homes, and the women themselves as they went about their daily chores. Spending time with families at home was critical to understanding how pregnancy and childbirth impact upon their daily life, and the different ways they modified their homes and daily routines (or not), to accommodate their needs during pregnancy, birth and postpartum care, as their home adapted to the growing number of children within it. Being present and participating in the multiple settings across which maternal health is practiced, allowed me to better understand the conditions under which maternal health provision works and, indeed, fails to work. This made it possible to better understand what pregnancy and childbirth involve in practice for rural women in the Andes.

In addition to the sixteen *gestante* cases, I recruited a wide range of informants from both Chiara and Izcuchaca's communities. In total, I interviewed 60 people over the course of the study – *gestantes* and family members, local authorities and community residents, including health professionals of whom 6 were obstetricians, 6 doctors, 4 nurses, and 2 trainee obstetricians (see Figure 18).

⁶⁴ It was not always possible to visit all of the *gestantes* I interviewed in Izcuchaca at home because of the distances they travelled from their village to the clinic.

Type of participant	N
Gestantes: expectant mothers (cases)	16
Family members and relatives	18
Health professionals, (comprising):	18
<i>(Obstetricians</i>	<i>6</i>
<i>Doctors</i>	<i>6</i>
<i>Nurses</i>	<i>4</i>
<i>Trainee Obstetricians)</i>	<i>2</i>
Local authorities and community residents	8
Total	60

Figure 18: Study Participants by type and number

Interviews

Aside from observation, ethnographers routinely employ interviewing to allow them to discuss, probe emerging issues or ask questions about unusual events in a naturalistic manner (Reeves, Cooper and Hodges, 2008:513; Hammersley and Atkinson, 2007a; 2007b). As part of this study, I conducted three different types of interviews, according to the type of participant I interviewed and the nature of information I required.

With *gestantes* and family members, I used a mixture of interview types: narrative, semi-structured, and informal, conversational interviews. In the case of narrative interviews, I employed ‘Tell me about’ questions, e.g. ‘*Could you tell me in your own words the story of (child)’s birth? Please begin at any point you wish*’ (Appendix 1). The use of narrative interviews, based around a ‘*tell me about...*’ structure allowed the participants to control the flow of the interview and prevented me, the researcher, from raising issues the participant themselves did not want to discuss or which they regarded as of a personal or sensitive nature. As I visited most *gestantes* and their family members on more than one occasion, I was able to continue with more focused interviews but also informal chats about their everyday lives; what it was like to live in Chiara or Izcuchaca and many other issues less directly related to the research project. In using a combination of interview types, on different occasions, I was able to reconstruct the patients’ maternal health histories and experiences from their point of view. With health professionals and local authority figures I used a semi structured

interview format, having prepared a list of topics for discussion in advance (Appendix 1). Nevertheless I took care to be flexible with respect to question order and responded to issues arising by introducing further questions in the course of the interview.

Upon completion of my fieldwork, from 60 participants, I had digitally recorded 37 formal interviews – 12 interviews with expectant mothers and relatives; five interviews with women who had given birth since 2009; 14 with health professionals; four with other key informants from the communities (local authorities and community residents), and two interviews with local *parteras* (community midwives). Interviews lasted from between 20 minutes to 2 hours, culminating in almost 65 hours of audio-recordings. I did not record informal interviews and conversations (23), preferring instead to take notes about the main topics.

All formal interviews were carried out in the setting chosen by the participant. With expectant mothers, recently pregnant women and family members in Chiara, it was important to conduct interviews in their homes, where they felt more comfortable. Here, at ease in familiar surroundings, the women and their families talked more freely of their experiences out of earshot of the health professionals. In Izcuchaca, I tried to interview mothers-to-be at home as often as possible, accompanying the obstetricians on their home visits and then once the obstetric visit had concluded I would stay behind and either informally chat or interview the woman depending on her preference. However, this was not always possible: many of the women visiting the clinic in Izcuchaca had travelled long distances from outlying rural communities. In such cases I observed their obstetric consultation and afterwards invited them to talk about the (pending) birth of their child with me. These interviews were carried out in another consultation room not being used for treatment at the time. I attempted to interview every participant alone, but in some cases, due to the young age of the mother-to-be for example, this was not possible. In terms of questions, interviews with patients and relatives had a central focus on pregnancy and birth. Issues covered included: a) the trajectory of the woman's pregnancy and all medical (or otherwise) treatment(s) associated with it; b) support strategies from family, neighbours or friends during the pregnancy c) problems faced; d) perspectives on pregnancy, antenatal care and birth; e) everyday life and routines whilst pregnant; and f) family members and family history (Appendix 1).

Interviews with health professionals were carried out in their consultation rooms or offices, although I frequently had non-recorded informal chats with many of them during fieldwork (especially with the obstetricians whom I shadowed most closely in Izcuchaca). These interviews covered a wide range of issues related to pregnancy, birth and postnatal care, its treatments and how various forms of support for patients are organised and delivered, as well as their views on the current maternal health policy promoting institutionalised birth across Andean regions. The interviews with non-*gestantes* in Chiara and Izcuchaca focused on everyday life in their respective communities and their thoughts and observations on having and raising children.

Throughout my fieldwork, I took detailed and extensive field notes, collecting more than three A5 notebooks of descriptions, summaries of interviews, insights and further questions. I usually began with descriptions of the scene or setting, followed by analytical and or methodological comments. I always carried one of my notebooks and also my voice recorder with me to jot down observations that I noted in the course of the working day. I later typed up these observations into full field notes when the *Posta de Salud* had closed for the night or my shift ended in the clinic. These notes became the main source of information and analysis in writing up the thesis.

Secondary sources

Documents and material artefacts also play an important role in ethnographic research as study materials, providing the ethnographer with important information about the context of the problem under study as well as information that would not otherwise be available (Hammersley & Atkinson, 2007a). During fieldwork, I paid particular attention to the kinds of texts and other material artefacts that I felt had a direct impact on maternal health in the settings in which it was practiced. For example, I followed how pregnancy and birth in Andean regions was portrayed in the media, particularly on television and the press, and identified several articles from local and national newspapers (from 2010 to 2016) that addressed or covered issues related to the research problem. These provided a sense of how maternal health was viewed outside of the confines of my field site.

I also collected ‘working’ documents, both official and unofficial, as well as other documentary materials related to pregnancy and childbirth. These included copies of training manuals for health professionals and ACS (Community Health Agents)⁶⁵, hospital posters with key messages for *gestantes* illustrated, Ministry of Health fliers promoting various types of contraception and copies of handmade maps, charts and drawings pinned to consultation room walls which were relevant to maternal health. These documents proved to be very valuable for understanding the way in which hospitals, clinics and *Postas* communicated with patients and family members, as well as their expectations concerning how pregnant women should manage their maternal health. In addition, these documents helped me to add local context and ‘flavour’ to the women’s detailed stories featured in the chapters to follow.

In Izcuchaca (but not in Chiara), many women and the obstetricians who cared for them permitted me access to patients’ *historiales* (medical records). Whilst patient records are stored centrally at the clinic, nevertheless in Peru, women accessing maternal healthcare through SIS, the government insurance programme, must carry their own documents pertaining to their pregnancy to each consultation. These documents include prescriptions, laboratory tests orders, tests results, hospitalisation summaries, receipts, antenatal scans, all serving to chart their encounters with the healthcare system, from attendance at hospital to visits to the pharmacy. Each patient I met had their own documents variously stored in woven plastic shopping bags, large manila envelopes or securely tucked into the depths of their *lliklla* – the brightly coloured woven cloths used to carry children or goods on their back. Among these assorted documents, the *tarjeta SIS* and their DNI – health insurance card and National Identification Card – were the most important, as these allowed them to access the hospital’s services free of charge under the insurance programme. The *historial* was very useful for reconstructing the patients’ maternal health history, as these contained a summary of the *gestante*’s reproductive health overall, her previous pregnancies and their outcomes.

Given the rural and remote nature of my field sites, I found photography and video to be an extremely useful medium for gathering data throughout my fieldwork. This helped me to record events and obstetric practices, copy MINSA documents in the

⁶⁵ The role of the ACS is discussed in Chapter 3.

absence of photocopying facilities in Chiara, and illustrate and explain the things I studied and encountered along the way.

Finally, I paid close attention to the different objects and equipment used in maternal healthcare, particularly key machinery such as Dopplers (foetal heart monitors), ultrasound scanning equipment and other obstetric equipment used in clinical settings. In addition I noted the equipment used in non-clinical settings such as birthing stools, blankets or animal hides, herbal infusions and *fajas* or binding cloths.

Data analysis

The nature of ethnography means that upon the completion of fieldwork, the researcher will have amassed a vast amount of data from different sources, all of which needs to be synthesised into a meaningful and coherent analysis (Grbich, 2012). Thus ethnography is not in itself ‘finished’ when fieldwork is completed but rather is an on-going process, whereby the ethnographer must disentangle the various strands of data collected to examine the detail of how each interweaves and connects to create meaning. The aim is to produce ‘rich’ detail and ‘thick’ description borne from insights gleaned from local context (Reeves, Kuper and Hodges, 2008; Cresswell and Miller, 2000).

A range of methods is available to the ethnographer in order to synthesise diverse forms of evidence, including narrative summary, thematic analysis, grounded theory, meta-ethnography, meta-study, realist synthesis, Miles and Huberman’s data analysis techniques, content analysis, case survey, qualitative comparative analysis and Bayesian meta-analysis (Dixon-Woods et al., 2005)⁶⁶. In seeking to synthesise my data and identify prominent or recurring themes emerging from the different types of data collected, I found thematic analysis techniques particularly helpful. Organising and summarising the data findings (and any supporting literature) under thematic headings (Dixon-Woods et al., 2005), I then produced summary tables providing descriptions of the key points emerging from my research (Mays, Roberts and Popay, 2001). In addition, ethnographers can also use methodological triangulation, comparing and contrasting different types of methods to help provide more

⁶⁶ See Dixon-Woods et al., (2005) for an overview of the advantages and possible drawbacks of each individual technique.

comprehensive insights into the phenomenon under study (Dixon-Woods et al., 2005). Triangulation is useful as sometimes what people say about their actions can contrast with their actual behaviour (Mays, Roberts and Popay, 2001; Reeves, Kuper and Hodges, 2008).

I also found more specific analytical processes, from the field of thematic narrative analysis (Reissman, 2008; Mishler, 1986a; 1986b) particularly helpful in analysing my data. Narrative analysis reconstructs the stories people tell, focusing on a specific event or issue to reach an understanding of how meaning is created through the ordering of stories. It examines what stories are narrated, how they are narrated and by and about whom (Reissman, 2008). In this way, the speaker connects events into a sequence consequential for later action, and communicates the meanings the speaker wants the listener to take away (Reissman, 2008). In collecting women's stories through the various stages of their pregnancies and exploring the problems they recounted in relation to accessing and maintaining maternal healthcare, their stories shed light on the realities of maternal health provision and access in local context. Their stories also make visible to us the gaps between reality and rhetoric in maternal health policy and the differences in expectations surrounding maternal healthcare for patients and practitioners. How policy is envisaged to work by policy makers, and how it is implemented, understood and practiced on the ground are very different things.

This ethnographic analysis will re-present those practices and difficulties in detail, in order to reflect the hardships and challenges faced not only by Peruvian women and their families, but also the health professionals charged with their care. To fully understand what is going on 'in the field', we need to examine the details. To that end, I have drawn on the widest range of ethnographic materials and insights in order to provide the most in-depth account possible.

Ethical considerations

The University of Liverpool's Committee on Research Ethics approved this study prior to me commencing fieldwork in Peru in 2010. The study also complies with the codes of practice of the University of Liverpool, American Anthropological Association and the European Association of Social Anthropologists, in their

emphasis on informed consent, data protection anonymity, non-maleficence and beneficence.

Access to participants in this research project was initially greatly facilitated by Claudio Chipana, a Peruvian friend of many years living in London. Upon learning of my intention to carry out an ethnographic study in the Peruvian Andes, whilst I was still considering where to carry out my research, Claudio suggested that I visit the village where he was born. He telephoned friends and local authorities in the village and requested their permission to allow me to visit. They responded favourably and in this way, Chiara became my first destination for fieldwork. My connection with Claudio opened many doors (both figuratively and literally) to me once in Chiara, granting me access to both health professionals working in the *Posta* who also knew Claudio as well as women and their families who lived in Chiara. At the *Posta*, I met Doctor Jeannette, who acted as an important ‘gatekeeper’ (Crowhurst, 2013) facilitating my introduction to patients and allowing me unrestricted access to consultations within the clinic.

As my research progressed, Doctor Grover, a physician working in private practice in Cusco whom I had known for many years introduced me to Janeth, an obstetrician and former work colleague, currently attending deliveries in the state run regional clinic in Izcuchaca. Janeth was interested in my research and suggested I ‘shadowed’ her throughout her shifts at the clinic. Again she acted as ‘gatekeeper’, presenting my request to carry out research to the Director of the Clinic who responded favourably. Janeth subsequently became a key informant throughout my research in Izcuchaca.

As my research participants were drawn from different walks of life, - being health professionals, local authority members, patients, their families, and so on – I employed different approaches to ensure informed consent was obtained and understood in this study. For those participants who were professionally involved in maternal healthcare, I provided them with written and verbal information about the research project in Spanish as well as what they could expect from their participation along with a consent form to sign (Appendices 4, 5 and 6).

For the women, their families and other residents of Chiara and the outlying communities around Izcuchaca, information was translated and provided in lay-Spanish, and consent taken in written and verbal form, dependent on the literacy and

preference of the participants (Appendices 2, 3 and 6). Where possible, verbal information was also provided in Quechua. It is important here to note the historical and political context in which this study took place. As I noted in my introduction, many women in the Andes underwent enforced sterilisations in the nineties under the Fujimori regime, often without prior informed consent being obtained. As a result, requests for signed consent, particularly from poor people around reproductive issues, are highly sensitive in Peru and can invite suspicion or raise concerns about what the provision of a signature or fingerprint might be subsequently used for. In all cases, therefore, I clearly explained the study, my work as a researcher and offered assurance that their participation was completely voluntary and that at any point they could stop participating or request to withdraw from the study. I assured anonymity and explained that anything I wrote up would not identify any of the study's participants in anyway.

Whilst the pregnant women attending the clinic in Izcuchaca were on the whole extremely willing to talk to me, the majority of the *gestantes* in Chiara refused to participate in the study, explaining they were afraid this would affect their relationships with health professionals and consequently their access to the state sponsored development programme *Juntos*, concerns that I draw upon in Chapters 3 and 4. Those in Chiara who agreed to participate, were women who were not currently pregnant, although the majority had given birth in the last two years. These women felt that talking about their past pregnancies would not cause them any undue problems with the health professionals, particularly as the staff had changed in the *Posta de Salud* since they had given birth. Where possible, I conducted at least two interviews with these women. As relationships developed with the research participants and their families, I was invited to have meals with them in their homes, where they often shared stories about their lives, their children, their work and what life is like growing up in Chiara and its environs. As fieldwork unfolded, many participants communicated to me that they felt I was both sensitive and sympathetic to them and the difficulties they were facing. This assured me that they were comfortable with my presence, the research project and my many questions. It is important to note that in Chiara, community life is extremely close knit, with family, friends and neighbours all living in close proximity to each other and thus knowing the intimate details of each other's lives. This intimacy also extends to health

professionals and community authorities, also drawn into the locals' lives, beyond their professional capacities, due to the close geographical proximity in which all inhabitants live. I argue that this accounted for the reluctance of many women in Chiara to openly tell their stories, whilst in Izcuchaca, because the town is much bigger and many women travelled to the clinic from their outlying communities this geographical distance from their own community afforded them a degree of anonymity not possible in Chiara, despite my assurances of confidentiality.

Consequently, to maximize anonymity and simultaneously minimize intrusion into the lives of my research participants in Chiara, I made sure my visits were at a time convenient for them. I did not want to disturb their everyday routines so I made sure my visits were sensitive to the rhythms of family life, and timed when the women were likely to be undisturbed at home. In this way, I hoped to avoid being seen 'actively' researching and inadvertently causing them difficult questions from third parties. My participants and I would often use an invitation to lunch, a Quechua lesson for me, or some assistance with their child's schooling by virtue of my profession as a teacher, as a convenient *raison d'être* for my being in their house, should an unexpected visitor come to call. In the context of my study, research ethics required constant consideration and reflection from me throughout fieldwork. As qualitative researchers focus their research on exploring, examining, and describing people and their natural environments, concepts of relationships and power between researchers and participants are ever present (Orb, Eisenhauer and Wynaden, 2001:93). Ethnographic research thus implies managing different expectations and understandings with many different informants, in a transparent and open manner (Orb, Eisenhauer and Wynaden, 2001). I was careful to achieve this throughout my study.

Thus, over the course of my fieldwork, I routinely introduced myself to health professionals and local authorities as a Spanish speaking English PhD student, studying at the University of Liverpool, with a background in education, an interest in public health issues and specifically the lives of Andean communities accessing maternal healthcare in Peru. While I introduced myself in a similar way to patients, I usually tended to disclose more personal details about myself, drawing on the two years I had lived in Cusco and my annual visits to the Andes ever since. As fieldwork progressed, I learned that research engagement, particularly when played out in the

context of a close-knit Andean community, necessitated *ayni* or reciprocity, like much of the work undertaken in the village. In this regard, I volunteered to help out at the local primary school, or attended literacy classes with the older residents in Chiara. I also tried to support the health professionals as much as I could, assisting with data entry on the lone computer in the nurses' room, or accompanying the doctor on public health *charlas* (talks) at the secondary school. I also helped her run the weekly elderly residents' evening, where for a few hours her consulting room would be turned into a social space to gather, chat, share problems, and receive health advice.

George Marcus has underlined the importance of the ethnographer to be adaptable to the changing settings of multi-sited ethnography, becoming a "circumstantial activist" (1995:95). In doing, the ethnographer may find themselves in unexpected and challenging ethical situations (Orb, Eisenhauer and Wynaden, 2001; Morse and Field, 1995). During fieldwork and my encounters with patients and their relatives, I certainly faced dilemmas I could not have anticipated: requests to lend or donate money to pay transport costs to hospital or purchase medication not covered in the SIS, to provide medical information or contraceptives, and even one request to adopt a child whom I had just witnessed being born! Such situations were beyond my capacity as a student or social scientist. In these situations, following the advice of Orb, Eisenhauer and Wynaden (2001), I directed patients to where I felt they could best receive help.

Reflexivity

Jane Richie (2003) draws attention to the importance of researcher reflexivity and empathy between researcher and participant. Throughout the study, I was always conscious of my own privileged position as a hybrid 'insider-outsider'. I grew up in Newcastle upon Tyne, in a middle class family, and whilst I have had the benefit of a university level education in the UK, I have also travelled extensively and lived for extended periods of time in Peru and more recently Bolivia. The year that I spent living in the coastal town of Chiclayo, in the north of Peru, followed by two years living and working in the Andean city of Cusco furnished me with enough first hand experience of the country's fragmented healthcare system to understand the challenges many of my study participants faced and the issues most at stake for them.

My time in Cusco also served to pique my interest in alternative approaches to medicine readily accessible in the Andes, which move beyond the ‘western paradigm’ so prevalent in the UK.

I returned from Cusco to live in the UK in 2008, relocating to London where I volunteered closely with the Latin American community in an activist campaign to gain recognition for Latin Americans as an ethnic minority from the various London councils; activism arising from the publication of the ‘No Longer Invisible’ Report published by Queen Mary University (McIlwaine, Cock and Linneker, 2011). This hands on experience with LARC and later with CLAUK⁶⁷ had an important bearing on my future research. Working with LARC afforded me greater insight into how ethnic denominations can be misconstrued, causing distress for the people who are incorrectly categorized, something that I had never experienced personally. This experience later influenced how I approached my research topic: I viewed ethnicity as a social construction, rather than something naturalized. In contrast to my position, when reading Ministry of Health (MINSA) documents around maternal health, I quickly discovered that MINSA regularly employs general markers such as “Andean”, “Amazonian” or “indigenous” to categorize large swathes of rural populations. Such generalisations overlook the complexities underlying ethnic identity. For example, “Andean” *can* be considered an ethnicity for some people, yet “Andean” simultaneously describes populations living in Ecuador, Peru, Bolivia, Chile and Argentina, based on their geographical proximity to the Andes mountain range. Within this general categorization, there are a vast number of different population groups and languages spoken, spanning five different countries. In Peru alone, there are 72 different ethnicities (Nureña, 2009:369; MINSA, 1999; IIP, 1994), each with their own traditions and culture, organized into 5069 rural communities in the Peruvian Andes alone (Nureña, 2009:369; MINSA, 1999; IIP, 1994). Given my history working with LARC, I find MINSA’s generalized classifications of “Andean” and “indigenous” to be inappropriate, particularly when such markers are used to denote ‘problem’ populations (Taylor, 2007) with high maternal mortality. The assumption made is that these populations are problematic precisely because of their

⁶⁷ LARC (Latin Americans’ Recognition Campaign):
<http://latinamericansrecognitioncampaign.blogspot.co.uk/> and CLAUK
<http://www.clauk.org.uk/recognition/>.

ethnicity. In turn, 'ethnicity' is used to highlight cultural practices, which are themselves turned into 'problems'. MINSA regularly presents the problem of maternal mortality as a 'cultural issue', as I have documented in my literature review and in subsequent chapters of this thesis.

My work with LARC also provided me with an initial introduction to ethnographic research methods as I became friends with an ethnographer carrying out research into the Latin American community in London who was also heavily involved in the campaign and whose meetings and events came to form an important part of her research.

My previous experience of living and working in the Andes coupled with my involvement with the Latin American community in London also helped me to recognise the importance of considering differing perspectives. I was aware of the complexities of coming to research maternal health as a (childless) academic researcher, from a foreign country. Here, I was not an activist, nor an expectant mother or medically qualified doctor, but someone working with pregnant women and health professionals to produce an account of their lives and social worlds that would likely not benefit any of them directly. The period of time I lived in the Andes, and the Andean friends I have made over the years in London whilst campaigning alongside them, increased my empathy, particularly given the kindness they extended me by accepting me into their lives.

Chapter Outlines

To conclude my methodology chapter and in order to situate the reader in what follows, I will introduce here a brief outline of the remaining chapters in my thesis.

Chapter 3, the first of five data chapters, describes how generalised maternal health policies are understood and put into practice on the ground in Chiara. I draw attention to the biopolitics of maternal health, showing how *chiarina* women are regularly surveilled and castigated when they do not comply with the rules of the social development programme *Juntos*, inextricably linked to maternal health provision in Chiara. I also show how the Ministry of Health responsabilises family, community members, local authorities and health providers through promotional campaigns and

direct pressure to ensure that pregnant women agree to give birth in state run clinics. The findings of the chapter situate the data in subsequent chapters.

Chapter 4 examines maternal health as ‘moral experience’ describing one *chiarina*’s attempts to manage her pregnancy independently of the *Posta de Salud*. The chapter follows her story as health professionals make it their moral and civic duty (de Zordo, 2012) to obtain her consent to a clinically managed birth. Describing and analysing this story in detail, paying attention to the difficulties encountered along the way by the woman and her family, in addition to the difficulties experienced by the health professionals in trying to persuade her to attend the clinic, helps to open up critical questions regarding institutionally and culturally constructed notions of what constitutes ‘good’ and ‘bad’ motherhood and ‘what is at stake’ (Kleinman, 1996) for rural women giving birth in the Andes today.

Chapter 5 moves from pregnancy to birth, exploring the links between family dynamics, *parto institucional* (clinically managed birth) and successful birth outcomes. I discuss how the Ministry of Health actively ‘recruits’ family members to persuade women to forego home births and deliver in MINSA run health establishments through the use of Delivery Plans, photographs and press releases depicting ‘culturally adapted’ birth scenarios. I expose the assumptions underpinning MINSA policy, highlighting that institutional expectations are often at odds with familial decision making processes. I show how women are vulnerable to obstetric violence when family support is absent or withdrawn, and I examine how the trauma of separation from family at birth becomes embodied in *post partum* illness.

Chapter 6 moves away from the clinic as a point of care to investigate how geography and logistics intertwine to shape maternal health interventions as rural women become identified as ‘problem populations’ (Taylor, 2007) by virtue of their geographic isolation. I discuss how health providers, under increasing pressure to enrol new patients, must actively seek out new patients ‘in the field’. This raises important questions about state legibility: the ability of the state to ‘see’ its citizens, and how health providers perceive that the state sees them. I show that geography and legibility also influence the ways in which health personnel are recruited to practice in rural areas with differences in contractual terms and conditions exacerbating tensions in an already fractured system.

Chapter 7, my final data chapter, explores the maternal health practices of Andean women that continue to take place within the home. Here I discuss the changing status of the *partera* (community midwife), whose work is currently illegalised under new policy directives. Despite her marginalised status I show how she continues to fulfil a crucial socio-cultural role for Andean women, not only attending to home births but also providing essential *post partum* care. She is joined by the *partera profesional*, a midwife with obstetric training, an emerging professional whose work is beginning to provide Andean women with an alternative to state run clinically managed birth. Ending the chapter, Yesica's story, from the perspective of both a *chiarina* and a *Posta* nurse, emphasises both the medical contradictions at play in current maternal health policy as well as the fallacy of relying on cultural assumptions. We see how Yesica chooses to give birth at home, and is able to harness her contacts within the Ministry of Health to allow her to do so.

Chapter 8, my concluding chapter, draws together the lived experiences and perspectives of rural women and health professionals pertaining to maternity as I have discussed in the different chapters of this thesis. In so doing, I frame my conclusions around a narrative extract from Elena's story (whom we first meet in Chapter 3), in order to discuss the key findings and different facets of Peru's maternal health 'problem' in the Andes today.

Chapter Three: Maternal Health as an Object of Governance and Monitoring

Introduction

In my literature review I discussed how the Ministry of Health (MINSA) has come to position Peru's high maternal mortality ratio as a 'cultural' problem pertinent to rural women of low socio-economic status and educational level across the Andes region (MINSA, 2010). For MINSA, indigenous women's traditional practices and rituals accompanying pregnancy and birth (Yajahuanca et al., 2013) are a cultural barrier obstructing the timely provision of clinically managed obstetric care at delivery (MINSA, 2009a; Thaddeus and Maine, 1994). In 2009, in attempting to overcome such challenges, the Ministry of Health introduced an important policy change: Andean women must be encouraged to forego their preference for home birth and agree to *parto institucional* (clinically managed birth). This policy, and the 'intercultural' initiatives that accompanied it, form the canvas upon which current maternal health provision in the Andes is painted. Together, they have placed culture centre stage and have had a profound effect upon the way in which maternal health is understood, practiced and negotiated in the Andes region today.

How *parto institucional* and its accompanying initiatives have come to be understood and applied in Chiara is the focus of this, my first data chapter. Having presented a general overview in my literature review, here I turn an ethnographic eye inward to examine what these policies mean in practice for rural women, their families, communities and the health professionals charged with their care. In so doing, I describe the difficulties occurring 'on the ground' for patients and practitioners alike when policies are applied in specific local contexts. This chapter also serves to ground my subsequent data chapters, providing the reader with an ethnographic insight into maternal health as it is practiced in Chiara today.

I begin by showing how maternal health is promoted as a public health priority within Chiara, focusing on how policy messages are communicated to residents through the generation of promotional material within the *Posta de Salud* (health outpost), drawing attention to the tensions emerging between practitioners and patients due to differing expectations regarding what should constitute maternal health provision.

The inextricable linkages between maternal health policy and the *Juntos* programme in particular are serious tension points between patients and practitioners. The incentivising nature of the programme encourages women to comply with maternal health strategies in return for financial reward. However, the conditionalities attached to the programme also bring sanctions when women do not comply, raising pertinent questions regarding the surveillance and monitoring of rural women's reproductive capacities *and* the work health professionals must do to ensure clinically managed birth happens. Milagros's story, recounted at the end of this chapter, illustrates how health professionals, *Juntos* coordinators and local authorities are drawn upon as actors in a programme, that exposes the biopolitics of current maternal health policy, restricting and in some cases suspending, the reproductive rights of Andean women and redefining the role of the health professional as an agent of the state.

Promoting maternal health in Chiara

Within days of my arrival in Chiara in October 2010 at the start of my research, I could see that pregnancy, birth and maternal health were pertinent topics in the village. One only had to enter the *Posta de Salud* to come face to face with a large, hand-drawn map of the village with red dots strategically scribbled at various intervals along the streets. These dots indicated where all the current *gestantes* (pregnant women) lived. Juan Antonio, the obstetrician working at the *Posta* would regularly update the map, as women gave birth and new pregnancies were confirmed at the clinic. Sellotaped to the wall, behind Juan Antonio's desk were several bright, eye-catching posters depicting cartoon-like images of heavily pregnant Andean women. The posters variously catalogued the danger signs to look out for in pregnancy⁶⁸ or encouraged Andean women to attend their nearest clinic for regular ante-natal check-ups. Another poster depicted a smiling *gestante* walking to the clinic on her way to give birth. In addition, a poster entitled *Maternidad Saludable, Segura y Voluntaria: Compromiso de Todos* (Healthy, Safe and Voluntary Motherhood: Everyone's Responsibility) (Figure 19) portrayed smiling members of a fictitious community. Tacked to the wall beside the posters was a small white piece of paper

⁶⁸ MINSA currently defines the danger signs in pregnancy to be: vaginal bleeding; burning sensation on urinating; swelling of hands or face; sudden increase in weight; fever; stomach pain or headache; blurred vision; ringing in the ears; liquid discharge. (Chapter 5 I reproduce the Delivery Plan (Figure 23) which details the danger signs given to pregnant women at their initial antenatal appointment).

upon which Juan Antonio had written in capital letters *Interculturalidad en Salud* (Interculturality in Health). Underneath were a series of pointers: recommendations from the current *Interculturalidad* policy detailing how health professionals were expected to incorporate intercultural healthcare into their everyday consultations with their Andean patients. Whilst the health professionals thus displayed promotional materials around the clinic in order to clearly signpost to their patients that maternal health was an important health priority, as my research progressed I came to discover that maternal health was a critical issue for everyone in the village and was considered a collective responsibility as the MINSA promotional campaign was designed to illustrate.



Figure 19: MINSA Promotional Campaign 2009: “Healthy, Safe and Voluntary Maternity: Responsibility of Everyone” (Source: MINSA.gob.pe).

Aside from the proliferation of promotional material in the clinic, the first indication of the particular importance of maternal health in Chiara was evidenced by the frequency with which pregnancy and birth cropped up in the conversations between the residents of the village. As I walked around the village, I often heard women discussing who was pregnant, or whom they suspected might be pregnant. However, it quickly became apparent that whilst the women happily discussed pregnancy with each other, they were somewhat more reluctant to discuss the issue with me. This reluctance piqued my interest: some women firmly but politely declined to discuss pregnancy or maternal health with me at all. I found it strange that in a village where

maternal health was a highly visible health priority, few *gestantes* were prepared to talk about their experiences or share their thoughts and opinions. However, as I got to know the residents of the village better, some of the women began to chat to me more often and they slowly began to reveal why they were so reluctant to discuss pregnancy and childbirth. One particular group of women ran the *Club de Madres* (Mother's Club), which met on a daily basis to cook and distribute the food supplements the more impoverished residents in Chiara received from various subsistence programmes.⁶⁹ These women in particular liked to chat with me as we shared a bowl of soup for lunch. It was here that I first learnt why some of the village women were reticent about talking to me. According to Marcelina, the President of the Club, the women feared that because I was living in the *Posta de Salud* (health outpost)⁷⁰, the health staff might overhear our conversation and "they don't want any problems". There was a suggestion that maternal health provision in Chiara was an issue of contention between the staff working at the *Posta* and the patients they care for. In order to find out more, I began to visit the women more frequently at home where I found they were much more willing to speak openly. Similarly, when I broached the subject of maternal health with the health professionals, I was particularly careful not to refer specifically to any particular woman, respecting the women's wishes that they did not want to draw attention to themselves. In this way, I came to learn how maternal health policy is interpreted and applied in Chiara and how the application of the policy is problematic not only for the women it is designed to care for, but also for the health professionals charged with implementing it, as I will show in the following section of this chapter.

Rewards, Sanctions and Rights

Several of the women whom I spoke to told me that should the health professionals discover that they had been openly criticising the maternal health programme in operation in Chiara they were likely to receive a *castigo*, or punishment. The women

⁶⁹ There were a number of government sponsored subsistence programmes in operation in Chiara such as PRONAA, *Vaso de Leche* (Glass of Milk) or *Crece* (Grow). All provided the poorest residents of the community of Chiara with basic food supplements with which to supplement their diet. The Mother's Club was in charge of ensuring the foodstuffs were prepared and distributed evenly amongst the community members. I will discuss another of these development programmes, *Juntos* (Together) as this chapter progresses.

indicated that the *castigo* was a consequence of a government sponsored cash transfer programme named *Juntos* (Together), in which many of them were enrolled. As I have shown in my literature review, it has become a common feature across Latin America for cash conditionality programmes to include healthcare and social inclusion⁷¹ commonalities as governments strive to achieve Millennium Development Goals (renamed Sustainable Development Goals after 2015). Similar programmes to *Juntos* are in operation in Brazil (Lindert 2006), Mexico (Smith-Oka, 2013) and Honduras (Borghi et al. 2006), linking the achievement of MDG goals related to education (MDG2), maternal health (MDG5) and child health and nutrition (MDG1 and 4). The *Juntos* programme operated in this way, explicitly linking maternal health to the conditional cash transfer (CCT) programme. The programme, as it operated in Chiara, required that pregnant women attended ante-natal appointments regularly; agreed to give birth in a clinical setting; and regularly took their young children to the clinic for their CRED (*Crecimiento y Desarrollo*: Growth and Development) appointment. In addition, emphasising the development aspect of the programme, families were required to weave a blanket that could be used in the family home for warmth. (Figure 20). In exchange, the families received a monthly allowance of 100 Nuevos Soles per child (Perova and Vakis, 2009a; 2009b; 2011). This money was distributed once a month on the village market day when women would line up outside the *Ayuntamiento* (Town Hall) and patiently await the receipt of their money (Figure 21), which arrived in a secure armoured van driven from the regional capital Andahuaylas.

⁷⁰ In Chapter 2 I discuss my living arrangements and the set up of the *Posta de Salud*

⁷¹ Social inclusion is defined as “the process of improving the ability, opportunity and dignity of people, disadvantaged on the basis of their identity, to take part in society” (Bordia Das 2013:4).



Figure 20 (left): Weaving a blanket as part of the *Juntos* development programme.

Figure 21 (right): Families enrolled in *Juntos* queue to receive their monthly allowance. The regional coordinator can be seen in red in the middle of the photograph.

The women explained that a number of sanctions emanated from this programme, including financial fines and public reprimand during *Juntos* meetings for failure to comply with the conditionalities of the programme. Should the women be found to have repeatedly not completed all the necessary tasks, the health professionals would report them to Sextos, the regional programme coordinator who could decide to suspend them from the programme and withhold their monthly cash allowance either indefinitely or on a permanent basis dependent upon how serious he felt their infraction to be. I wanted to learn more about the ‘*castigos*’ (punishments) that the *chiarinas* had mentioned. I asked Juan Antonio if I could accompany him to the next Public Health *Charla*⁷² (talk) in the town which was regularly held in conjunction with representatives from *Juntos* to learn more about how the programme functioned.

The meeting began with Juan Antonio calling a register of all the women enrolled in the *Juntos* programme to ensure that they were present. Absences were noted and women arriving late were asked to explain publically the reason for their late arrival. Several women cited family commitments, such as children to care for or agricultural

⁷² As part of their job description, health professionals must regularly hold public health talks with the community to disseminate information. Topics may include the dangers of drinking alcohol, smoking, mental health, nutrition, contraception and pregnancy etc.

work in the *chacra*⁷³ as the reason for their late arrival. Each woman was then warned that if she continued to arrive late, or skip meetings all together then she risked being removed from the programme. One woman in particular, Isabela, was told that she would be removed from the programme because she had missed several meetings and was thus judged by Juan Antonio not to be taking the programme seriously enough. Isabela was a designated Team Leader, which meant that Juan Antonio assigned her certain public health responsibilities. One of these was to coordinate the dissemination of public health information to the group of local women who made up her 'team'. As Team Leader she was charged with ensuring her team effectively communicated public health messages within their neighbourhood.⁷⁴ Her repeated absence at meetings according to Juan Antonio was thus setting a bad example to the other women. Isabela began to plead with him, citing her children and household responsibilities as reasons for her prolonged absence. She said that if the money she received from the programme was stopped, this would cause her great financial difficulty. She told Juan Antonio she was aware of her responsibilities to the programme and would ensure she carried them out fully in future. She looked as though she were about to cry and Juan Antonio relented and told her to sit down, warning her to make sure she kept to her word. The public health topic for presentation that day was on nutrition. Juan Antonio spent the next 20 minutes talking through the necessary components of a balanced meal for the women and their children, reminding them that the money received from *Juntos* was to be used to provide nutritional supplements for their children. The meeting ended with all the women present being reminded that they must adhere to the rules of the *Juntos* Programme or face being removed from it. Juan Antonio asked several women to enunciate the rules: they must bring their children to the *Posta* for their check ups and vaccinations; pregnant women must attend all antenatal appointments and give birth in the clinic in Huancaray. Juan Antonio reiterated to the women that failure to give birth in the clinic would also result in a financial fine being levied against the woman in question and the confirmation that the child had been born in the clinic would of

⁷³ The *chacra* is a Quechua term used to denote a smallholding of land belonging to an individual or family, which they use for agricultural purposes. See Chapter 2 for more details.

⁷⁴ *Chiarinas* from different areas of Chiara were regularly assigned responsibilities by the Obstetrician in relation to public health. Working alongside the ACS – the Community Health Agent – they were charged with the dissemination of public health information and campaigns. A second responsibility was to inform *Posta* staff of any pregnant women in the village. I discuss the role of the ACS in more detail later in this chapter.

course be withheld. This documentation is of vital importance: without it the parents of a child are unable to obtain a birth certificate for their newborn. In turn, without a birth certificate, the child cannot be legally registered as a Peruvian citizen. The child therefore does not receive a DNI card, the official state national identity card, which affords all Peruvians access to health services and education and awards them the right to work and vote. Thus, by threatening to withhold such documentation, the clinic and by extension the state, turn childbirth into a biopolitical issue whereby reproductive rights and the rights of the newborn child are granted in return for adherence to certain norms: in this case institutionalised birth. A mother's failure to comply means that her child's right to be recognised as a Peruvian citizen is seriously compromised.

The biopolitics of the Peruvian state's current maternal health policy are apparent from the examples cited above. Mothers enrolled in the *Juntos* programme are obligated to attend regular meetings where they are rewarded for complying with the rules of the programme and punished if they do not. Health professionals are expected to monitor the women's actions, report infringements of the rules to programme supervisors and mete out sanctions which include financial levies, public beratement and in extreme cases, removal of non-compliant women from the programme. The state apparatus thus draws upon Foucauldian norms of social regulation and self-governance⁷⁵ to monitor and control women's reproductive capacities. (see also Murray de López, 2016; Krause and de Zordo, 2012; de Zordo, 2012; Morgan and Roberts, 2012; Waldby and Cooper, 2008). For Foucault, biopolitics⁷⁶ is used to describe a "specific modern form of exercising power" (Lemke, 2011:33). Liberal governance, subjectivation processes and moral-political forms of existence create a "political anatomy of the human body" (Foucault, 2008:317), permitting an exploration of moral problematizations of biological (and reproductive) experiences and forms of self-constitution (Foucault, 1988, 1990). Biopolitics, for Foucault, thus came to represent the disciplining of bodies and the regulation of the population

⁷⁵ Foucault's concept of biopolitics broke with earlier naturalist and politicist interpretations linking biopolitics with biological determinants (see Kjellén, 1924; von Verschauer, 1936; von Kohl, 1933; Roberts, 1938; Mathieu, 2003) and political processes and structures (see Gunst, 1978; Cauthen, 1971; Anderson, 1987; Gerhardt, 2004; van den Daele, 2005, cited in Lemke, 2011).

⁷⁶ Lemke (2011) notes that Foucault's conceptualisations of biopolitics (and biopower) changed over time. Earlier interpretations employ biopolitics as a historical rupture in political thinking and practice, characterized by a rearticulation of sovereign power. A second interpretation links biopolitical mechanisms to a rise in modern racist ideology (Lemke, 2011:34).

through forms of (liberal) governance. As I have shown, maternal health policy in Chiara relies upon the disciplining of women's bodies and the regulation of their reproductive experiences.

Following Foucault, feminist anthropologists argue that biopolitical arrangements emerge from global discourses on maternity as they are lived out in practice across distant places and settings, diverse contexts and societies (Krause and de Zordo, 2012). Policies and practices differ in their specifics and yet – from Western Europe and post-Socialist Europe, to Asia and Latin America, feminist scholarship emphasises that women around the globe, as the main target of reproductive policies, continue to experience conflict related to their reproductive practices, and are stigmatised for their reproductive behaviours (Unnithan, 2015; Unnithan and Pigg, 2014; Krause and de Zordo, 2012; Morgan and Roberts, 2012; Alvarez, 1998). For Krause and De Zordo, “more than babies are at stake” (2012:140): citizenship, personhood and rights, “the most basic elements of being human” (ibid) become enmeshed in “fertility politics” (Krause and De Zordo, 2012; Krause and Marchesi, 2007). As I have shown above, tied to the conditionalities imposed upon them via state run cash transfer programmes, in 2011, impoverished women in Peru must trade their right to decide where and how they wished to give birth in exchange for the right to register their child as a Peruvian citizen.

The reproductive rights of Andean women enrolled in the *Juntos* programme to decide how and where to give birth are also challenged in more nuanced ways by health professionals and programme monitors. As Tara Cookson (2016) has noted in her ethnographic study of the *Juntos* programme operating in Cajamarca, northern Peru, it is *not* an official requirement of the programme for participants to deliver in a health establishment, and yet clinically managed birth is routinely presented to women as a stipulation of the programme. Cookson terms these unofficial programme conditions ‘shadow conditionalities’, citing a *Juntos* meeting in which the programme coordinator and the *Posta* nurse publically contradict each other in front of the programme's participants attending the meeting. The *Juntos* coordinator insists that hospital births are obligatory and the young female nurse disagrees, saying that whilst they are *not* obligatory, “they are better” than home births questioning what would happen “if something were to go wrong” during delivery at home (2016:1199). The *Juntos* coordinator then threatens the women present with sanctions and suspension

from the programme if they do not give birth at the health post, echoing Juan Antonio's actions as I have documented earlier in this chapter. My research supports Cookson's findings, showing that 'shadow conditionalities' also operate within the *Juntos* programme in Chiara. However, it is important to note here that in Chiara, it was not just the *Juntos* officials stipulating obligatory clinically managed birth for rural women, but the health professionals too. In so doing, Chiara's health staff, under pressure to ensure their patients comply with policy directives promoting delivery in a health establishment, harness the *Juntos* programme as a mechanism to achieve policy aims, causing tensions to arise between them and the very patients they are employed to care for as I have illustrated.

Lynn Morgan and Elizabeth Roberts have noted the propensity for 'rights-bearing citizens' to be "pitted against each other" in this way, in claiming their reproductive, sexual, indigenous and natural rights (Morgan and Roberts, 2012). They note that in Peru, women have historically been the focus of 'reproductive governance'⁷⁷, from the limitations of indigenous women's fertility through clandestine population control under Fujimori's regime lasting from 28 July 1990 - 22 November 2000 (Introduction; and also Coe 2004; Ewig 2010a; 2010b); to the official attempt at the expansion of state surveillance of all Peruvian women's reproduction during the Toledo administration of 28 July 2001 – 28 July 2006 (Introduction; and Coe, 2004). My research shows that reproductive governance is not only a historical phenomenon in Peru, but continues today. Women's reproductive rights are pitted against the rights of their child to be registered; restrictive maternal health policies dictate how and where Andean women are to give birth; health professionals become recast as 'agents of the state' in ensuring these policies are implemented. Such policies, presented as 'intercultural' initiatives, social inclusion and development programmes, are framed around women's rights to have their cultural practices and reproductive rights respected (MINSA, 2009a; 2009b). However, as Maya Unnithan and Stacey Pigg (2014) have noted, as human rights frameworks increasingly pervade health development policy, planning and programmes globally, and most markedly in countries of the global south, there is a growing sense that reproductive rights have

⁷⁷ Reproductive governance refers to the mechanisms through which different historical configurations of actors – such as state, religious, and international financial institutions, NGOs, and social movements – use legislative controls, economic inducements, moral injunctions, direct coercion, and

arrived but reproductive and social justice has not followed (2014:1181). The restrictions, rewards and sanctions currently placed upon the maternal health choices of rural women in Peru via the *Juntos* programme attest to this.

It is also important to note here, when discussing reproduction in a Latin American context, that Foucauldian biopolitical interpretations reflect an Anglo-American set of assumptions, which present difficulties when drawn upon to account for what may be happening elsewhere (Kierans, 2015). State structures in Anglo-American settings are well defined and thus permit the state to accurately surveil its subjects through registration processes (Scott, 1998; Caplan and Torpey, 2001), something that maybe incomplete or absent in other countries, such as Peru. Although most citizens have a national identity card, this is not always the case in remote areas, given the difficulties imposed upon rural women in registering home births as discussed above, the continued high levels of illiteracy across Andean regions and the remoteness and distance of many rural communities from administrative capitals. Drawing attention to the globalised south, Veena Das (2001) acknowledges that the capacity of individuals to engage with state forms of governance is not knowable in advance, nor are such individuals knowable to or governable in similar ways by the state. In terms of health coverage, in Peru for example, large swathes of the population remain without health insurance (Arce, 2009) and thus do not have the capacity to engage with state actors⁷⁸ in claiming their reproductive rights. Morgan and Roberts (2012) also emphasise that ‘rights’ in the Latin American context, are often pursued collectively across citizenry, rather than focusing on an individual woman’s rights and her reproductive choice.

Nevertheless, a reading of the feminist literature helps us to see that biopolitical agendas clearly underpin the implementation of maternal health policy in Chiara, as rural women are expected to adhere to particular rules which govern their pregnancy and reproductive bodies. Adherence results in financial reward through incentivising programmes like *Juntos*, whereas, for women who fail to follow the rules, financial sanctions are forthcoming. Vania Smith-Oka (2009; 2012a; 2012b; 2013), in her ethnographic studies of indigenous women’s reproduction practices in Mexico, also

ethical incitements to produce, monitor, and control reproductive behaviours and population practices (Morgan and Roberts, 2012:241).

⁷⁸ I take up this point in more detail in Chapter 6.

highlights the biopolitical underpinnings present in *Oportunidades*, a Mexican cash transfer programme similar to *Juntos*. Smith-Oka highlights the paradoxical nature of such programmes, which promote the empowerment of women, through direct participation, and yet simultaneously serve to disempower them, by forcing them to comply with the rules of the programme. For example, *Pláticas* or community talks, are offered in Mexico – and also in Chiara as I have documented - as a means to educate the community in public health scenarios. They are regarded by practitioners as an effective way to impart information to patients: by participating directly in such meetings the women receive information on self-care – particularly about nutrition for themselves or their families, how to keep their homes and environments clean, and how to recognise the symptoms of basic illnesses (Smith-Oka, 2013:131). In terms of maternal health, family planning information, and advice surrounding self care during pregnancy are offered. In this way, such talks are promoted as a vehicle to empower women, empowerment being reflected in the reproductive choices they make over their own bodies: the number and spacing of children through family planning initiatives and when and how to give birth (Smith-Oka, 2013). The current focus on Interculturality and the option of *parto vertical* (vertical birth) promoted in MINSA policy literature in Peru (Nureña, 2009) is designed to further encourage empowerment and participation through greater reproductive choice. However, as I have shown above, the *charlas* are often used as a means to implement punitive measures; employed to reprimand women for their failure to comply with the rules of the programme, in addition to being used as a vehicle for promoting the health professional's own ethical viewpoint. The use of public-shaming tactics, whereby women such as Isabela are publically called to account, is seen by researchers as a means of exercising a gendered social control over the female participants in the programme, what Lamia Karim (2008) has coined “an economy of shame” in her critique of gender biased development programmes in Bangladesh. Following Smith-Oka, I argue that such programmes thus serve to disempower women and the control they have over their own bodies as they are constantly monitored, sanctioned and ultimately removed from the programme if found to have failed to follow the rules. By placing the responsibility for such monitoring in the hands of physicians, Smith-Oka further asserts that physicians unintentionally become agents of the development programme, a situation which makes them “doubly-powerful” in a local context as they control not only access to healthcare but also access to development programmes

such as *Oportunidades* in Mexico (2013:124). Nurses and obstetricians in Chiara also fulfilled this dual role as healthcare providers *and* monitors of the *Juntos* programme as I have documented. However, I challenge the assertion that in so doing they become “doubly powerful”. As I show below, *Juntos* not only has a disempowering effect on the women enrolled in the programme, but also the health practitioners charged with its effective implementation.

Surveillance and Monitoring

In requiring that health professionals monitor their patients’ attendance at regular meetings and note down absences, missed antenatal appointments and other infringements of the programme, *Juntos* places health professionals under tremendous pressure and is a source of friction between them and the patients they care for. For example, Yesica, one of the two full time nurses working in the *Posta*, told me that the monitoring of the *Juntos* programme was one of the worst aspects of her role:

“I hate doing this part of the job. I am going to tell the doctor I don’t want to do it anymore. It is always me who has to tell the women they can’t be in the programme or take their supplements away. I am sick of being the bad nurse”.

Yesica was responsible for monitoring the women’s attendance at the clinic because she regularly carried out the CRED health checks for children less than five years of age. In 2010, Yesica was the only health professional working at the clinic who was born and grew up in Chiara and as such was regarded by the *chiarinos* as ‘one of them’. Her father, before his death in 2009, had been an important authority figure in Chiara, previously occupying the role of Community President. Yesica’s husband, Pedro, was the current Governor in the village. Yesica was therefore held in high regard by her fellow *chiarinos* and was a familiar and reassuring figure at the *Posta*. Further, she was the only nurse in the clinic who spoke Quechua as her first language, which further strengthened her relations with her patients, as they were able to converse easily with her in their first language⁷⁹. Indeed, *Salud Sin Limites*, a government sponsored NGO in Peru, in its *Interculturality* training manual for health staff (2004), recognises that access to health information in a patient’s native

language is of vital importance. Including PAHO's "Human Rights and Health" document on Indigenous Peoples in Annexe 3 of their training manual they quote:

"In order to introduce more access solutions, the Ministries of Health, Education and Culture can encourage the preparation and diffusion of informative health materials in local languages, the inclusion of leaders/traditional *curanderos* in health promotion and mutual learning, capacity building and information exchange via workshops on traditional medicine knowledge and practices in line with the right to freedom of expression".

(Health Personnel Training Manual: Interculturality in Health. *Salud Sin Limites*: 2004)

The assumption made is that communication between patient and practitioner will be eased when information is shared in the patient's native language. However, in Yesica's experience, as a direct consequence of the *Juntos* programme, the fact she was the only nurse to speak fluent Quechua exposed her to difficult situations and on occasion, verbal abuse from patients who were angry when she had to tell them they were being sanctioned for not adhering to the rules of the programme. One evening, I found her in tears at the clinic after having had an argument with a patient who had disagreed with her assessment that she had missed several appointments at the clinic. Yesica was duty bound to report the patient's absence to Sextos, the programme's regional administrator. As a result, it was likely the patient would be excluded from the programme for several months until such time as the family brought their children to the clinic for their CRED appointments once more. Although Sextos would authorise the exclusion, Yesica was responsible for communicating this information to the patient. On another occasion, I witnessed a distressed male teenager run into the clinic and verbally threaten Yesica in Quechua with physical violence after he had learnt she had just informed his mother that she was in danger of losing her monthly allowance for failure to bring her youngest child to the clinic for a health check. It took direct intervention from Sextos to restrain the teenager before the staff managed to calm him down. Such scenarios thus lead Yesica to conclude that she was seen as a "bad nurse" amongst the *chiarinos* and this had a disempowering effect on her own perceptions of her role. As a direct result of acting as monitor for *Juntos*, Yesica felt

⁷⁹ Juan Antonio, the Obstetrician, also spoke Quechua as his first language. However, he was from Ayacucho, a neighbouring town. Thus, Yesica was the only local Quechua-speaking health professional working at the clinic.

that her position as a nurse at the *Posta* was compromised. Further, her social position within the community was also negatively affected: she no longer felt that her community regarded her in the same way as before. She had come to be regarded as the “bad nurse”; the one who struck patients off from the programme and made their life difficult by removing their monthly allowance and nutritional supports.

Yesica’s experiences show that health professionals’ practices are also circumscribed by policy demands. In monitoring their patients and being made to report missed appointments to the programme coordinators, they themselves are also being monitored. Monitoring occurs not only within the *Juntos* programme, as they are obliged to pass on information about absentees, but also within the Ministry of Health itself. Practitioners’ everyday dealings with their patients are subject to close scrutiny by DIRESA, the regional directorate for health. For example, each month, MINSA employed health staff must submit a digital copy of their consultations to DIRESA. The details of the HIS (*Historial de Salud*: Patient Health Record), which is completed on paper at the time of the consultation, must be entered manually into a computer. To do so takes up at least two days of the health professionals’ time as they close the *Posta* to patients, in order to work uninterrupted to meet the deadline for data entry. In order to help the *Posta* staff meet their deadline for data entry at the end of each month, I would assist them at their request by spending several days at the computer typing in the relevant codes. Yesica would dictate them to me, insisting that I could input the data quicker than she could. The information entered is then overseen by DIRESA. If a particular health establishment fails to meet its targets for the number of patients seen and the particular type of appointment, DIRESA contacts the establishment indicating that they are being monitored. Often, in both Izcuchaca and Chiara, I overheard health staff commenting that their reports had been returned marked *observado*, or “noted”. When patients miss antenatal appointments in particular, or fail to give birth in a MINSA health establishment, not only are the patients sanctioned as I have shown above, the health staff are also in danger of being investigated. If they are subsequently found to have failed to discharge their duties correctly, they are likely to be discharged from their duties by the Ministry of Health. Doctor Carlos, a peripatetic dentist who visited Chiara every few months, told me of an investigation carried out by MINSA the previous year when a woman had given birth at home in a neighbouring village instead of the assigned clinic in Huancaray.

The Ministry of Health launched an investigation and concluded that because sufficient numbers of women were not attending the clinic for antenatal appointments or to give birth, the obstetrician was not therefore carrying out his duties in the correct manner. He was subsequently dismissed from his post. Doctor Grover, a physician who previously worked at the MINSA health clinic in Izcuchaca and who has now moved into private practice, explained the intense pressure placed on health staff due to constant monitoring and potential sanctioning thus:

“Unfortunately if I, in my position as the Director of the health centre, have a maternal death they (MINSA) will throw me out. What is worse is that I will now have a maternal death registered in my service record and therefore, so that I can get another job I will probably have to go as far as the north of Peru to find another job, so that they won’t find out that I did that, as if I were the guilty party”.

Doctor Grover continued, explaining that as a consequence of the constant monitoring of statistics by the Ministry of Health, coupled with the possibility of dismissal as narrated in the quote above, health professionals are forced to manipulate statistics and create falsified consultations in order to be seen to be meeting their targets. In addition, he believes that the very organisation of the health service system is also problematic. The Ministry of Health currently pays an amount to the clinic for each patient seen. In rural areas such as Chiara and Izcuchaca, many patients are enrolled in the SIS (*Seguro Integral de Salud*), a state funded health insurance programme offered to families and individuals judged to be living in poverty (Arce, 2009). MINSA currently also reimburses the costs incurred to the clinic when attending to a SIS registered patient. Doctor Grover told me that as a consequence:

“(There are) ghost consultations that don’t really take place whereby (health professionals) simply fill in a health appointment record because they know that they will be paid for it or the Health Insurance Programme will cover the cost...and so they fill in a Patient Record as if the patient had come to the clinic. I have seen consultations – when I was in charge of monitoring the SIS insurance programme, when it was known as that⁸⁰ - I saw what was going on because I did an audit of the Patient Records that we filled in...and in there I found that during the previous management’s administration, so that they could be seen to have carried out more consultations there were medical

⁸⁰ The SIS Insurance programme was replaced with the AUS (Aseguramiento Universal de Salud: Universal Health Insurance) in 2010 (see Arce, 2009). In practice, both patients and practitioners continued to refer to it as the SIS in both Chiara and Izcuchaca.

records...consultations and medical records filled in for a patient who was already dead at the time of the supposed consultation”.

Thus Doctor Grover’s words make visible the lengths that health staff must go to in order to be seen by MINSA to be meeting their targets. Since 2009, key maternal health targets are to ensure that women attend their antenatal appointments at the clinic and agree to give birth in an institutionalised setting (*Plan Estratégico* Report, MINSA 2009:6), as set out in the current *Estrategia Sanitaria Nacional Salud Sexual y Salud Reproductiva 2009-2015*⁸¹ (National Health Strategy for Sexual and Reproductive Health 2009-2015) as I discussed in Chapter 1. To facilitate this eventuality, the Ministry of Health simultaneously launched the *Maternidad Saludable, Segura y Voluntaria: Compromiso de Todos* (Healthy, Safe and Voluntary Motherhood: Everyone’s Responsibility) campaign in 2009, a poster of which hung in Juan Antonio’s examination room in Chiara as I documented in opening this chapter. I now turn to examining in more detail how the Ministry of Health utilised the *Compromiso de Todos* campaign to position maternal health as a community-wide responsibility and how the campaign was interpreted and drawn upon by health professionals working in Chiara to obtain rural women’s compliance in the managing of their maternity.

Community Responsibilisation

The publicity poster and accompanying information leaflets (Figure 19) for the *Compromiso de Todos* campaign presented colour images of a cross section of residents from an imaginary village: a pregnant woman; a miner or construction worker, possibly the woman’s husband; the uniformed obstetrician, doctor and nurses from the health clinic; a suited authority figure who could variously be interpreted as the community President, Governor or Mayor; a representative of the local security forces and Police. In presenting the community members in this way the poster thus placed collective responsibility for maternal health outcomes firmly within the community.

The campaign carefully draws upon the historical notion of *ayni* (reciprocity), prevalent amongst rural Andean communities. It reflects the traditional collective

obligations and collaborations in the *comunidad campesina* (rural community), which form the backbone of agricultural labour. Neighbours and community members are expected to mutually assist each other in sowing and harvesting crops. In Chiara, I witnessed examples of *ayni* (reciprocity) and *minka* (community work) on several occasions: beyond reaping and sowing crops, *minka* extended to repairing drainage ditches damaged by flooding or construction work on neighbours' houses and community buildings (Figure 22). *Minka* is not a gendered activity: men, women and school children are expected to participate in Chiara and monetary fines are levied against community members who fail to participate in community *minka* called by the village authorities. The failure of community members to complete *minka* is *observado* (noted) in regular community meetings in the village hall. Mutual assistance and reciprocity, and a communal responsabilisation for work needing to be carried out in the village are long standing traditions, deeply embedded in daily life in Chiara. *Chiarinos* understand the necessity of attending to them to facilitate the smooth running of daily life for all in the village. *Ayni* and *minka* are therefore respected and regularly carried out.



Figure 22: *Minka* (Community Work): Building a neighbour's house in Chiara.

I argue that the Ministry of Health has drawn upon communal understandings of reciprocity and communal responsabilisation amongst agricultural communities to

frame its *Compromiso de Todos* campaign. The visual creation of an imaginary community in promotional posters, representing a cross section of different actors fulfilling different social roles (health professionals, village authorities and family members for example) extends the idea of ‘community’ into maternal health provision. The slogan “Everyone’s Responsibility” further emphasises communal responsabilisation. Parallels are drawn with community work: just as communal agricultural work in Chiara is understood to be everyone’s responsibility, maternal health scenarios are also positioned to be so. Just as community members are fined for their failure to carry out their *minka* responsibilities and publically called to account, pregnant women and their families are fined and publically berated when they fail to abide by the rules of the *Juntos* programme. Just as community authorities note when communal workers fail to meet their *minka* responsibilities, so health authorities note when health professionals’ miss targets or fail to ensure rural women’s compliance to maternal health policies. Taking the organisation of agricultural life in rural communities as a starting point, the Ministry of Health has thus attempted to promote maternal health in the same way.

It is essential to note here however some critical points overlooked in the design and implantation of the *Compromiso de Todos* campaign. Understandings of *ayni* and *minka* have emerged over time from *within* rural communities, and are discussed and managed by *chiarinos*. Policy makers, in designing maternal health campaigns, often do so without consulting the communities they are intended to support, therefore marginalising their involvement (Berry, 2005; 2013; Kvernflaten, 2013). The acceptance of policies imposed upon rural agricultural communities by external organisations cannot therefore be assumed. Anthropologists have noted that policies implemented without due consultation with local populations fail to meet their needs (Portocarrero et al, 2015; Berry, 2005; 2013; Glei, Goldman and Rodriguez, 2003; Cosminsky, 1982). In Chiara, for example, although promoted as a community responsibility, the transportation of pregnant women to the *Casa Materna* in Huancaray, was problematic, often solved on an *ad hoc* basis, responding to who was available at the time.

Mothers-to-be must discuss their “Birth Plan” with the obstetrician,⁸² in which they specify how they intend to travel to the clinic to give birth, who was going to accompany them and how and with whom they would travel in an unexpected situation such as the early onset of labour. Most women in Chiara cited their family members as being those who would assist them in a routine journey to the clinic. Important local authority figures such as the Mayor or the President were called upon to assist in an emergency situation as they had access to a vehicle, or could mobilise members of the community with vehicular access to drive the woman to the clinic in Huancaray. Nominated drivers with available vehicles were displayed in the *Posta de Salud*. However, because village authorities were often away attending to business with neighbouring communities, and the reality of everyday life required that potential drivers were also working at considerable distance from Chiara attending to the *chacra* (cultivated land), in reality pregnant women frequently had to make their own way to the *Casa Materna*, on public transport or by foot.

Further assumptions underpinning the *Compromiso de Todos* campaign fail to consider the key importance of the historic past into which maternal health across the Andes is embedded. The campaign assumes that when the pregnant woman, her family and key community members take joint responsibility for maternal health, the outcome will be, as the slogan suggests, “healthy, safe and voluntary motherhood”: the woman will be safely delivered of her baby with the help of the health professionals. Members of the pregnant woman’s community are responsabilised to ensure that the mother-to-be arrives safely at the clinic prior to giving birth, as I discussed above.

However, the specific use of the term “voluntary motherhood” in this campaign drew my attention, particularly in light of the recent historical and political context within which women’s reproduction in Peru is situated. As Vania Smith-Oka has documented in Mexico, feminist organisations first coined the term “voluntary motherhood” in the late 1960s, to describe their efforts to advocate for free and legalised abortion (Ortiz-Ortega, 2005). Centred on taking control over their reproductive lives (Ortiz-Ortega and Barquet, 2010), in addition to abortion rights, their demands also included sexual education and an end to enforced sterilisation

⁸² I discuss the Birth Plan in more detail in Chapter 5.

(Billings et al. 2002; Lamas 1997). As in Mexico, enforced sterilisations were also commonplace for indigenous women in Peru. The Fujimori regime (28 July 1990 - 22 November 2000) utilised sterilisation programmes to specifically control the population demographic of indigenous populations in the early Nineties (Miranda and Yamin 2004; Coe 2004; Chávez and Coe 2007; Ewig, 2010b), as I have discussed in my introductory chapter. When the coercive and clandestine nature of these sterilisations was revealed in 2002, causing both national and international outcry (Coe 2004; Ewig, 2010b; Morgan and Roberts, 2012), the biopolitical underpinnings of reproductive policy were laid bare. When Alejandro Toledo took office in 2001, two key shifts in reproductive policy occurred. Firstly, Toledo worked to make state institutions recognise the rights claims of indigenous groups, in wake of concerns about the ability of indigenous populations to reproduce themselves in the aftermath of the mass sterilisation campaigns (Morgan and Roberts, 2012). Secondly, to appease the Catholic Church, Toledo proposed a legal reform requiring all Peruvian women to register their pregnancies at the time of conception to protect the rights of the unborn child (Morgan and Roberts, 2012). Thus, as Morgan and Roberts (2012) underline, a clear shift in reproductive governance occurred in Peru during the Fujimori and Toledo administrations. Reproductive policy measures introduced by Fujimori seriously limited indigenous women's fertility through covert population control measures, whilst Toledo spearheaded an "official attempt at the expansion of state surveillance of all Peruvian women's reproduction through the rhetoric of rights" (Morgan and Roberts, 2012:246) whilst simultaneously cutting back access to reproductive health services including condoms, emergency contraception and post-abortion hospital care (Coe, 2004).

Seen in light of this historical and biopolitical context then, I posit that by framing the *Compromiso de Todos* campaign around the idea of "Voluntary Motherhood" MINSA's aim was two-fold. Firstly, to promote family planning methods, but secondly to also signal to indigenous communities that the enforced sterilisations of the Fujimori era were firmly assigned to a past chapter in Peru's history. However, as my research progressed, from my conversations with both the health professionals and the women who lived in Chiara and Izcuchaca, it became apparent that key authority figures and community members were also required to intervene directly to ensure rural women's compliance with maternal health policy directives, bringing into

question the terminology of “voluntary motherhood”, and exposing once again the ‘biopolitics of reproduction’ (Waldby and Cooper, 2008) underpinning such initiatives. Governance through biopower, in which subjects come to govern themselves on intimate bodily levels (Foucault, 1990), is today achieved through development programmes like *Juntos*, and promotional campaigns like *Compromiso de Todos* that assign responsibility to different social actors within the community to ensure women’s adherence to maternal health policy. By drawing upon notions of community responsabilisation, the state continues to harness biopower - insidious forms of self-surveillance and self-regulation (Smith-Oka, 2013:94) - to refashion women’s reproductive behaviours.

One way in which this was done in both Chiara and Izcuchaca was through regular meetings and training sessions held between health professionals and their *Agentes Comunitarios de Salud* or Community Health Agents (ACS)⁸³ who worked on a voluntary basis for MINSA. ACS must be members of the general public living in the local community. They can volunteer for the post but must be approved by the other community members. In Chiara, this was done at the regular General Community Meetings held every month to communicate important information to village residents. Their work is to promote good health practices on an individual, family and community level. In terms of maternal health provision, the 2007 training manual for the ACS defines their role as being one in which they are to:

“promote maternal health; encourage healthy eating during pregnancy and encourage new mothers to breast feed”. (MINSA/DGPS/DPCS 2007:10-11)

In Chiara the role of the ACS was principally to act as a community health worker visiting residents at home, disseminating community health messages and reporting any patients’ concerns back to the appropriate member of staff at the *Posta* best placed to offer medical help where necessary. In terms of maternal health, this meant that the ACS was responsible for liaising between the pregnant women in the village and the staff. For example, the ACS may visit the *gestante* at home and discuss aspects of pregnancy, ensure she is aware of the danger signs to look out for, check she is eating well and report any concerns back to the staff.

⁸³ ACS are also referred to as *Promotoras de Salud* or Health Promoters in both Chiara and Izcuchaca

In Izcuchaca, after one such training meeting, I spoke with Flor, a recently appointed ACS, about her role. She is a former Governor in the district of Puyjura, located 25 minutes from Cusco and in addition to being an ACS, she also acts as Justice of the Peace in her community. Flor told me she loves her role as ACS, enabling her to work “hand in hand” with the health staff to help her community. She described her work in relation to maternal health thus:

“We identify (maternal health) cases and as Health Promoters we are obliged to go to an establishment – by that I mean a Health Centre – and report what is wrong, or sometimes there might be a family history. Often we pick up on problems the mother is having. For example, there might be a pregnant mother who has a family violence problem at home. So, what do I mean by that? As much as the mother may eat, if there is violence, blows, insults...all of these things have a psychological influence. So we have to...in practical terms we are authorities even if only inside of our own particular community. So we identify these cases immediately, we advise the health establishment... which in my area is a *Posta*”.

Thus, the ACS, in carrying out his or her duty, also has a more nuanced role to play. As Flor’s words show, being a member of the local community, and thus interacting on a more regular basis with his or her fellow residents, the ACS is also expected to identify and inform the *Posta* staff of any newly pregnant women in the community. In addition, the ACS must report any familial problems they may identify. In Chiara, the ACS is expected to report a pregnancy to the *Posta*, regardless of whether the pregnant woman discloses her pregnancy to the ACS or not⁸⁴. In this way then, the ACS is positioned to play the role of a watchful monitor over women’s reproductive health. In Chiara, the ACS would regularly inform the *Posta* staff of women they suspected may be pregnant, either due to their own observations, chit-chat they had overheard from other women in the village or because a woman had directly told them she was pregnant. Smith-Oka (2013) describes the role of the *Promotora de Salud* in Mexico as “a go-between for the surveillance of women”, particularly in clinical settings (2013:129). Thus given that the ACS in Chiara, must immediately pass information regarding pregnant women directly to staff in the clinic, I felt better placed to understand the reticence that some of the women had in discussing

⁸⁴ I will discuss the consequences of such actions and the reactions of the pregnant woman concerned in the following chapter of this thesis.

pregnancy with me upon my arrival, and their fears that I in turn may relate their conversations back to the *Posta* staff.

However, as time progressed and the women in Chiara became accustomed to seeing me walking around every day, it became easier to strike up friendships with them. I became good friends with Milagros, a 27 year old, married woman who lived in Chiara, although she was originally from the neighbouring community of Talavera. Milagros had two children: a daughter, aged 10 years old in 2010, and a baby son. Milagros would often invite me to her house to eat lunch and we would sit outside in the sun chatting whilst she nursed her son. Her conversation would invariably include references to her son's recent birth, which is where I came to learn how local authority figures are further drawn upon to assist in implementing maternal health policy in Chiara.

Milagros's story

Milagros, as all women in Chiara are required to do, had given birth to her son in the clinic in Huancaray in a routine birth. However, she had found the experience to be traumatic, principally because once she had given birth, her blood pressure had risen alarmingly and she was transferred as a medical emergency case by helicopter to a hospital in Lima for treatment. She was transferred alone, her husband had to make his own way to Lima by bus, a journey of over 24 hours across torturous terrain from the highlands. Miguel, her newborn son, remained behind in Huancaray where he was cared for by immediate family. Milagros's narrative was often punctuated by references to feeling alone and frightened, as she travelled to the hospital and was admitted for emergency treatment without her husband or family accompanying her. However, in telling her story, she also made very clear how she was made to travel against her wishes and those of her husband at the insistence of the health professionals who put great pressure on her to travel. When she refused, the health professionals enlisted the help of the local authorities to ensure Milagros's compliance:

"I didn't want to go. That night, (the authorities) visited my husband...they took him to the Police station. "How are you going to guarantee your wife's safety? She has to go to Lima". "She wants to stay here, so here she stays" my husband told them. They didn't want that. "If she stays she will die. We have to tell you

that”. “She’s bleeding, she has high blood pressure...how is she supposed to travel like that?” “She is going to go or you will be held responsible for her life.” That’s what they said to my husband. “She will go but she better come back healthy”. My husband came back and said to me “You have to go”. I didn’t want to. People die...they even take your blood, a nurse told me you can die from that. “I am not going”. I didn’t want to. They didn’t even want me to take my son with me. “No, I’m not going” I said. I didn’t want to go. “I’m not going without my son. I’m going to go with him”.

Thus, Milagros’s story clearly makes visible how health professionals and local authorities exert pressure on family members to ensure that pregnant women modify their behaviour to conform to expected norms. When Milagros refuses to travel, controls are put in place to ensure she changes her behaviour. Firstly, doctors in Huancaray exert pressure on her husband to persuade him to change his wife’s opinion. When he also expresses his objections, the health authorities call in the local Police to resolve the matter. Milagros’s husband is told by the local Police in Huancaray that he will be held responsible should his wife die. When he still refuses to allow her to travel, explaining that she is bleeding and has just given birth, his opinion is challenged and he is asked how he is going to guarantee her safety. It is made clear to Milagros’s husband that he will be held responsible under Peruvian law if his wife should die as a result of his refusal to allow her to travel to Lima for treatment. Thus, he has no alternative but to agree. Accordingly he is forced to tell Milagros she has to travel, regardless of her wishes. Her desire to travel with her newborn son is also overlooked: she is separated from her son and travels alone by helicopter. In this way, health professionals and authority figures situate family members to build a moral imperative: the responsibility for his wife’s maternal healthcare is passed to Milagros’s husband. His actions will decide the outcome: if he refuses to allow her to travel she may die and he will be legally responsible. By positioning the responsibility for maternal health outcomes with family members and the wider authorities in this way, what is essentially a public health scenario becomes the focus for a moral intervention.

Milagros’s experiences echo scenarios cited in public health research illustrating how moral responsibility is transferred to patients and family members across public health interventions. Anthropologists have shown how ‘risk’ is designated a cultural construct that powerfully shapes patients’ experiences (Smith-Oka, 2012). Within the

field of social science, Deborah Lupton's work examines the aspects of 'risk' associated with surveillance and governability: she links 'risk' to the apparatuses inherent in biopolitics showing how the state strives to discipline and normalize its citizens. "Risk" is presented as a sociocultural construct and a person is deemed 'self responsible' for their own health (Lupton, 1999). Carole H. Browner and Nancy Ann Press (1995) have shown how 'risk' in pregnancy is considered to be minimized by human or technological intervention. Consequently, a multitude of tests, best practices and concerns should be followed to ensure a favourable outcome. When a woman is perceived to flout these rules, problems arise resulting in "increased medical gaze" to reestablish authority. However, as Fordyce and Mareasa (2012) have noted, this approach, practiced by health professionals, ignores the wider practical realities that face many women like Milagros. Consequently, miscommunication, a lack of informed consent and perceptions of non-compliance result (Fordyce and Mareasa, 2012:8). As Smith-Oka (2012:2276) points out, blame is central to notions of risk, and it is often the women – or their families – who are held responsible. In this way, risk is used to construct a 'moral community' (Douglas, 1990): individuals are expected to police their behaviours, and the behaviours of others, to better serve their – and their state's - health (Smith-Oka, 2012). Following Lupton (1999), a person thus becomes responsible for his own health. Should a woman die in childbirth therefore, she is held responsible and blamed for her own death by engaging in risky behaviour that transgressed expected norms (Smith-Oka, 2012:2276).

Following this argument, we can see how local authorities – in this case the Police – are able to pass the responsibility for Milagros's potential death to her husband. By refusing further medical treatment she is engaging in risky behaviour. If he does not persuade her to modify her behaviour, she is likely to die and the responsibility will be passed to him. This echoes the findings of Aaron Denham (2012) who has carried out ethnographic research in Ghana investigating trajectories of blame for infant illness or death. He has shown that as Ghanaians come to rely more on a biomedical framework for their healthcare rather than a traditional medicine based one, the blame is shifted when an infant death occurs. Rather than blame spirits, the blame is increasingly placed with the mother and her actions. Outside the realm of maternal health, wider ethnographic research has further shown that moral responsibility for favourable health outcomes is often placed outside of the clinical domain. For

example, Ciara Kierans and Jessie Cooper (2011) have shown how the moral responsibility to ensure appropriate matching of organ donors to recipients in the UK often is passed to minority ethnic groups in the context of transplant medicine; similarly, Julie Taylor (2007) has documented how AIDS victims in Africa are held morally responsible for their health outcomes as their ill health is blamed on their irresponsible behaviour patterns when following treatment regimes.

Milagros's story also shows us how maternal health outcomes are positioned as a family and community wide responsibility in the Andes, underpinned by promotional materials such as the *Compromiso de Todos* campaign. In Chiara, such is the pressure placed on health professionals to ensure their patients follow the norms in relation to maternal health, that local authority figures are called upon to intervene when the patient refuses to act in the manner expected. The authorities in turn pass the responsibility firmly back to the family to ensure the patient modifies her behaviour; in this case Milagros's husband. As Milagros is in Huancaray having given birth there, the local Police are called in this instance to put pressure on her husband. Had she been in Chiara at the time, given that there is no Police force there, the village authorities, such as the Mayor, the President or the Governor would have been called upon to intervene. State interventions have negatively impacted on Milagros's memory of her son's birth to such an extent that she told me that she no longer wished to have any more children and was receiving contraceptive injections from the *Posta*.

Conclusion

In this opening chapter, I have described how the current Peruvian maternal health policy, which requires that women give birth in institutionalised settings, is promoted, understood, and applied in local context and provides a critical backdrop to this study. The strategies health staff use in Chiara to ensure women give birth in the clinic in Huancaray include the careful positioning of promotional posters, charts and fliers advocating clinically managed birth around the *Posta de Salud*, signalling to women in Chiara that their maternal health is a top health priority. Maternal health has also become inextricably interwoven with *Juntos*, a conditional cash transfer programme operating in the village.

Pregnant women enrolled in the *Juntos* programme in Chiara must regularly attend antenatal consultations at the *Posta de Salud*, and agree to a clinically managed birth in Huancaray. However, the requirement to deliver in Huancaray is a ‘shadow conditionality’ (Cookson, 2016): an unofficial condition of the programme harnessed by health professionals in their dual role as programme monitors, to ensure rural women agree to give birth in a state-run health establishment. In fulfilling this dual role, health professionals become recast as agents of a state-run programme that exposes the biopolitical underpinnings of current maternal health policy, restricting and in some cases suspending, the reproductive rights of Andean women.

Women are monitored and surveilled through a series of health encounters, whether they be public health meetings, clinical consultations or home visits from health staff, community health agents or local authorities. Mothers-to-be are routinely surveilled as they go about their daily routine. Health professionals call them to account when the demands of everyday life – such as tending to their crops, caring for their other children or domestic chores cause them to be late to public health meetings, as we have seen in Isabela’s case. A failure to comply with the norms of the programme triggers biopolitical interventions from both health practitioners and the state. Economic sanctions and suspension from the programme are common practice; participants who fail to meet the imposed conditionalities, like Isabela, are publicly berated during public meetings.

It is not just rural women who succumb to the biopolitics of maternal health: health professionals are also monitored, surveilled and sanctioned in the course of their work, under pressure to ensure that the women they care for during pregnancy and birth agree to a clinically managed delivery. In addition, they are also subject to administrative interventions from DIRESA, the regional health authority. Obligated to input data concerning the number and type of consultation carried out, when targets fall short, health professionals’ reports are returned *observado*, or noted. Doctor Grover’s testimony highlights how staff will resort to manipulation of statistics and even register fictitious consultations to avoid sanctions. In terms of maternal health, staff are under constant scrutiny, with encounters between local practitioners and the regional health authority taking the form of investigations and inspections, regularly carried out to ensure that norms are followed, resulting in sanctions and dismissal if procedure is found to have been followed incorrectly.

Backed up by promotional campaigns such as the *Maternidad Saludable, Segura y Voluntaria: Compromiso de Todos* (Healthy, Safe and Voluntary Motherhood: Everyone's Responsibility) campaign, maternal health is designated a collective responsibility: key community members are drawn into maternal health practices to ensure compliance with the required rules. Milagros's experience, as she is flown by helicopter to Lima after the birth of her son, show clearly how authority figures from beyond the public health realm are called upon to intervene in maternal health scenarios.

In this chapter in choosing to focus upon how policies and programmes relative to maternal health provision and access are implemented and accessed in Chiara, I have exposed the biopolitical interventions underpinning pregnancy and birth. I have shown how monitoring and surveillance strategies permeate maternal health encounters between different actors, across different sites and on different levels, threatening the reproductive rights of rural women accessing antenatal care and delivering in state run health establishments. In the following chapter, I build upon the research presented here, moving beyond the policy domain to examine maternity as it is lived as everyday experience by rural women in Chiara. To do so, I focus upon the story of Rosalinda, a local *chiarina* woman in her ninth pregnancy. In the telling of Rosalinda's story I will show how routine pregnancy and birth become positioned as 'moral experience' (Kleinman and Benson, 2006) as Rosalinda, in refusing to follow policy protocols, is perceived as also refusing to conform with culturally constructed notions of 'good' motherhood.

Chapter Four: Maternal Health as ‘Moral Experience’

Introduction

The previous chapter was grounded in an examination of the biopolitics of maternal health policies and programmes in Chiara. I showed that rural women are regularly monitored and surveilled, and their reproductive rights curtailed as they are obligated to comply with ‘shadow conditionalities’ (Cookson, 2016) emanating from the *Juntos* programme. It is not just rural women who succumb to the biopolitical arrangements at play: health professionals are also monitored and surveilled in the course of their work, under pressure to ensure that the women they care for during pregnancy and birth agree to a clinically managed delivery. Family, authority figures and members of the local community are also responsabilised to ensure the mother-to-be complies.

Building on these findings, this chapter provides a vantage point on women’s lived experiences of maternity, moving away from maternity as policy and instead highlighting the routine and everyday experience of what it means to be pregnant and have a child in Chiara today. In so doing, I will focus upon pregnancy as ‘moral experience’ (Kleinman, 1999a; 1999b; 2006), defined by Arthur Kleinman as experience

“Characterised by an orientation of overwhelming practicality. What so thoroughly absorbs the attention of participants in a local world is that certain things matter, matter greatly, even desperately. What exactly is at stake, across local worlds and historical epochs, varies, sometimes extravagantly so”. (Kleinman, 1999a:360).

After Kleinman, in attempting to uncover what matters greatly and what is therefore at stake for rural women and their maternal health, I have chosen to structure this chapter around the story of Rosalinda, a married, 42 year old woman living in Chiara and pregnant with her ninth child. Following the peculiarities of Rosalinda’s pregnancy through to the birth of her child and beyond, enables us to see what is important for Andean women, their families and community members as they negotiate the intricacies of Peru’s current maternal health programme, previously described in Chapter 1. Rosalinda’s maternal healthcare trajectory, as she chooses to

forego antenatal care and informs staff she intends to give birth at home, caught the attention of both *chiarinas* and health professionals. Both were interested in Rosalinda's actions, although each had very different reasons for turning their attention towards her. We will see how wider structural issues such as child care responsibilities, the organisation of the family home, and the pragmatics of everyday life in an agricultural community make it difficult for rural women like Rosalinda to conform to expected notions of motherhood. At the same time, institutional norms surrounding pregnancy and birth lead health professionals to view it as their "moral and civic duty" (De Zordo, 2012) to persuade women who do not follow expected reproductive trajectories to modify their behaviour. It is at this disjuncture – where institutional expectations and the constraints of everyday life collide - that health staff, neighbours and community authorities draw upon institutional constructions and cultural understandings of what it means to be a 'good' or 'bad' mother to ensure that Rosalinda succumbs and agrees to a clinically managed delivery.

Rosalinda's Story

I met Rosalinda within the first week of my initial visit to Chiara. I first heard about her from the *Posta* nurses during their lunchtime conversations. They would invariably sit around a rickety wooden table, drinking *infusiones* (herbal teas) and watching Mexican soap operas broadcast on an old black and white TV in their living quarters. With one eye on the soap opera, the nurses used this time to chat to each other about events unfolding at the clinic in Chiara, or to discuss their patients. The nurses suspected that Rosalinda was pregnant. Pregnancy was one of the nurses' favourite topics of conversation. They, like the local women they cared for, enjoyed speculating on how many women in the community were currently pregnant, suspected to be pregnant or planning to be pregnant. Rosalinda, once her pregnancy was confirmed was one of five women currently pregnant in the village. She was a *chiarina*, 42 years of age and, like the majority of Chiara's population, a native Quechua speaker. She lived in a run-down mud-brick house built around an interior patio. The house was positioned on the hill overlooking the *Posta de Salud*. She lived there with her husband Victor, a musician who regularly travelled away from home to play the Andean harp in *fiestas* held in neighbouring communities, an occupation which provided the family with their principal source of income, in addition to their

100 *soles*⁸⁵ a month from the *Juntos*⁸⁶ development programme. Their eight children also shared the one-roomed family living quarters. Her in-laws lived across the patio in a second mud-brick dwelling and the communal space in between was shared with a selection of animals including Rosalinda's herd of goats, a pig, several lambs, chickens and guinea pigs. Rosalinda's main occupation, like the majority of women living in Chiara, was as a housewife and subsistence farmer. Her busy schedule began at dawn when she, like the rest of the *chiarinos*, would rise and having prepared breakfast for herself and her family, would lead her animals out to pasture. She could often be seen across the valley, a small, distant figure silhouetted against the burning sun, leading her goats across a mountaintop. When at home, her time was spent caring for her children and running the family home with all of the accompanying chores this involved: including washing the clothes, cooking, and sweeping the yard. Like all the *chiarinos* who lived from subsistence agriculture, she would also spend many hours in the family *chacra*, a small plot of land, cultivated to provide grains such as quinoa or amaranth and root vegetables like potatoes or carrots, the mainstay of the *chiarino* diet.

A Pregnancy Confirmed

Rosalinda's suspected pregnancy drew the interest of the nurses and her community for several reasons. Her fellow *chiarinos* had seen Rosalinda tending to her daily business as usual: leading her goats to pasture, caring for her children, washing her clothes, completing her household chores or walking around the village. However, the *chiarinos* had noted that beneath her wide *pollera*, the traditional wide woollen skirt worn by all women in the village, Rosalinda appeared to be pregnant. The fact that Rosalinda may be pregnant again was not however the principal reason why she was rapidly becoming the main topic of conversation amongst the nurses and the *chiarinos*. What was of particular interest to them was that Rosalinda appeared to be trying to conceal her advancing pregnancy behind layer upon layer of *pollera*. By so doing, Rosalinda was not only attempting to disguise her pregnancy from the *chiarinos*, but also from the health professionals working at the *Posta de Salud*. In short, whilst it appeared that Rosalinda was pregnant, she was pretending not to be.

⁸⁵ The *Nuevo Sol* is the official currency in Peru, commonly known as the *sol*. Four *soles* are equivalent to £1.

As a new researcher recently arrived in Chiara, I quickly became interested in finding out why a married woman might choose to hide her pregnancy from her fellow community members and health professionals and why her suspected pregnancy was of such interest to the residents of Chiara in general.

Rosalinda's previous pregnancy had ended eventfully with her giving birth in the street "like a cow", as the wife of the current Mayor had explained to me. She had a history of home births and was known in the village for failing to attend her antenatal appointments at the clinic. In our lunchtime conversations the nurses opined that they were sure that her current pregnancy – once confirmed – would end the same way. Reacting to the rumours reaching him from the *chiarinos* and the Community Health Agent (ACS)⁸⁷, Juan Antonio, the Posta's obstetrician and a native Quechua speaker from the neighbouring town of Ayacucho, visited Rosalinda at home to ascertain whether she was indeed pregnant or not.

Juan Antonio returned from his home visit to Rosalinda extremely worried. He estimated that she was some 31 weeks pregnant. Until his visit, Rosalinda had not received any form of antenatal care during the course of her pregnancy. Current maternal health policy requires that all community women attend their nearest MINSA run health clinic to have their pregnancy confirmed as early as possible and thus begin their antenatal care. Rosalinda's pregnancy should have been routinely monitored until such time as she would travel to Huancaray, to the referral clinic, to give birth⁸⁸. However, Rosalinda had not done any of these things either during her previous pregnancy, and neither as Juan Antonio believed, was she likely to do so this time around. Rosalinda had told Juan Antonio that she wanted to give birth at home as she had always done.

Rosalinda's earlier decision not to attend her antenatal appointments and her refusal to travel to Huancaray to give birth during her previous pregnancy was thus another principal reason why news of her new pregnancy had sparked such interest amongst health professionals and *chiarinos* alike. Her decisions and actions during the course of her previous pregnancy had placed her in direct contravention of the norms governing maternal health provision and her current actions – the concealment of her

⁸⁶ The preceding chapter discusses how *Juntos* operates within Chiara.

⁸⁷ I discussed the role of the ACS or Community Health Agent in the preceding chapter.

⁸⁸ Chapter 2 explains the structure of health provision in Chiara.

pregnancy, her refusal to attend the clinic for antenatal care and her declaration that she wished to give birth at home – indicated that she was prepared to do the same again. Her attitude sparked the interest of other *chiarinas* – particularly those women of childbearing age – whose maternal health choices depended upon such policy norms. Rosalinda's pregnancy was of interest to them precisely because she refused to accept the norms surrounding maternal health provision in Chiara. In so doing, she also sparked the interest of the health professionals at the *Posta*. Whilst both *chiarinas* and health professionals were thus interested in Rosalinda's actions, each had very different reasons for turning their attention to Rosalinda. I will show how her actions help us to understand what is at stake for the different actors who play a role in the telling of her story.

Risk and vigilance: the obstetrician's viewpoint

For Juan Antonio, Rosalinda was a 'risky patient' (Chapman 2006; Gálvez 2012; Smith-Oka 2012a) whose actions made his job difficult. By failing to attend the clinic Rosalinda was a medical risk: her safety and the safety of her baby could not be monitored. Furthermore, her actions also placed him, and the health professionals he worked alongside, in a compromising situation. As health professionals it was their responsibility to provide for her maternal healthcare. By failing to attend the clinic this care could not be given: Rosalinda was evading maternal healthcare strategies put in place to regulate and monitor reproduction within the community⁸⁹.

Rosalinda's actions and the nurses' reactions show a difference in priorities for patient and practitioner. Health professionals face difficulties and pressures trying to implement current maternal health policy in local settings. The community obstetrician is responsible for ensuring an institutionalised birth to save lives (Nureña 2009). In the preceding chapter, I discussed how the Regional Health Authority, DIRESA, closely monitors health professionals to ensure they are following correct procedures and meeting their targets in relation to patient appointments. Rosalinda's actions were therefore likely to place Juan Antonio under intense scrutiny once DIRESA learnt of her refusal to attend the clinic for her antenatal appointments. If anything were to happen to Rosalinda or her baby during the course of her pregnancy,

⁸⁹ See Chapter 1: Health and Social Policy

the Ministry of Health would subsequently demand explanations from the health professionals at the *Posta de Salud*. Were Rosalinda to give birth at home, this would trigger an investigation by the Health Authority based on the assumption that the staff were failing to provide adequate care as I discussed in the previous chapter.

Under such pressure, I observed how *Posta* staff repeatedly tried to convince Rosalinda to attend the clinic in order that her pregnancy be monitored. Their actions echo the findings of Vania Smith-Oka (2013) in her work on risk and reproduction (see also Inhorn, 2007) amongst indigenous Mexican women. Documenting how problems arise when a woman is perceived to disregard the bureaucratic and institutional norms surrounding maternal health provision, she suggests that often the situation results in increased vigilance by health professionals to reinforce medical authority (2012a; 2275). Following Smith-Oka's findings, I witnessed how the *Posta* staff repeatedly visited Rosalinda at home in order to minimize the possibility of her giving birth there. Thus, they continually tried to convince Rosalinda and her family that she should attend the *Posta* for her antenatal care listing the possible dangers to her life and the life of her unborn child. In conversations with Victor, her husband, Juan Antonio, the obstetrician highlighted the supportive role that the *Posta* can play in Rosalinda's antenatal care and birth plan. When he and the other *Posta* staff failed to make headway Juan Antonio turned to threats, warning Victor that he has the authority to cut the family's subsistence allowance from the *Juntos* programme. Thus, as documented in the preceding chapter, conditional arrangements are often brought into play to place responsibility firmly on the shoulders of the women and their husbands enrolled in the programme: mothers are expected to follow policy norms in order to receive their cash allowance. If they do not, economic sanctions follow. Aware that the health professionals' visits to her home were largely to reiterate that she must come to the clinic to give birth, Rosalinda responded by often hiding in her house in order not to have to speak to the *Posta* staff about her maternal healthcare.

Moderating 'bad behaviour'

Rosalinda's continued refusal to come to the clinic for her antenatal care was not viewed kindly by the *Posta* staff. Juan Antonio, continued to visit her regularly at home to check on the progress of her pregnancy. I accompanied him on several such visits. Often when we arrived at her home, located a short walk uphill from the *Posta*,

Rosalinda was not there. Instead, she could be seen in the distance leading her herd of goats out to pasture. On other occasions, she would be seated in the yard in front of her home about to do her washing, bent over a huge plastic tub filled with cold water on the ground. These activities simultaneously worried and angered Juan Antonio, who would spend considerable time variously reprimanding her for her ‘bad behaviour’, such as ignoring his advice to rest or else trying to cajole her to come to the clinic so she could be properly monitored. I also accompanied Doctor Jeannette and Yesica, the Quechua speaking *Posta* nurse, as they too made home visits. After each visit the *Posta* staff would discuss Rosalinda’s situation with me, describing her as variously “irresponsible”, “manipulative”, “disgraceful” and “stubborn” for her continued refusal to conform to their expectations. Her behaviour was explained, in general, as a result of “ignorance” and on one occasion, Rosalinda was labelled a “liar” by one of the nurses after she had told the nurse she would come to the clinic⁹⁰. The comments and attitude of the health clinicians towards Rosalinda illustrate how they not only believed Rosalinda to be putting her own life and the life of her baby in danger, but further, they judged her behaviour to be inappropriate.

My findings support the work of Silvia de Zordo (2012) who has shown how biopolitical rationalities operate in family planning services provided to low income, black women in Brazil. She argues that health professionals see it as their “civic duty” to ‘educate’ poor people so that they may ‘rationalise’ their desires and plan the size of their families in line with their socio-economic capabilities. In addition, poor people have the civic and moral duty to postpone or at least plan their pregnancies. Failure to do so is viewed as a failure to create ‘good citizens’ and a failure to effectively utilize family planning as a mechanism to “turn human reproduction into rational practice” (Foucault, 1976, quoted in de Zordo, 2012:208). The health professionals in Chiara judge Rosalinda to be “irresponsible” precisely because she has not chosen to limit the size of her family. She does not use family planning methods; she is now in her ninth pregnancy at the age of 43. Like the low-income Brazilian women in De Zordo’s study, Rosalinda does not adhere to expected norms of reproductive behaviour. As the mother of a large family, like her Brazilian counterparts, her refusal to limit her reproduction is “irresponsible” and “shameful”

⁹⁰ Which she in fact did, although whilst she greeted me she ignored the said nurse without so much as glancing in her direction.

(de Zordo, 2012:218). Further, as a woman of impoverished socio-economic status, Rosalinda ought to 'live within her means', which health professionals, concerned with family planning targets, understand to mean having fewer children.

In addition, Rosalinda fails to carry out her expected social role: she continues to work, leading her animals to pasture and completing her domestic chores. She ignores obstetric advice to rest and come to the clinic for antenatal checks. She refuses a clinically managed birth. Such reproductive trajectories – in the eyes of the health professional – are determined by 'culture'⁹¹ and 'irrational' behaviour (de Zordo, 2012:209).

Juan Antonio continued trying to convince Rosalinda to agree to give birth in Huancaray. To this end, he invited Victor, Rosalinda's husband, to the clinic to discuss the situation with him. The nurses were also present at the meeting and Juan Antonio was happy for me to be present too. The meeting began amicably, but when Victor insisted that his wife did not want to give birth in Huancaray and he could not make her do something against her will, the atmosphere became tense. Victor continued speaking, explaining that the organisation of family life makes it difficult for Rosalinda to attend the clinic to give birth: she has eight children to care for and feed in addition to the animals to lead to pasture and the crops to attend to. Victor cannot allow his wife to attend the *Casa Materna* to give birth; their other children will be left with no one to care for them whilst they are away. He missed his last son's birth as he was working: the subsistence agriculture upon which the community depend makes it extremely difficult for a family to travel and stay for several weeks at the *Casa Materna* located two hours drive away. Financial pressures add to the difficulties: the family live in extreme poverty. Rosalinda's healthcare is provided for under the SIS, the health insurance package offered to low income families⁹² but her travelling and daily expenses, and those of her family are not⁹³. One of the *Posta* nurses interrupted him to state, "She has to comply. She is putting her life at risk". Victor replied saying, "She knows what to do. She knows how to give birth. She does not need you." When Victor left, the nurse commented that he was a *machista* (sexist)

⁹¹ Health professionals interviewed by de Zordo conceptualized 'culture' "as an ensemble of 'backward' beliefs and 'traditional', 'absurd', 'irrational' practices that patients would abandon after being 'enlightened' by the biomedical rationale." (2012:218).

⁹² See Chapter 3

putting his wife's life and the life of his child at risk. Her comment reflects anthropological findings showing how health practitioners harness *machismo* (sexism) as a convenient gloss to overlook their patients' economic and family problems, such as poverty and gender inequalities (see Krause and de Zordo, 2012; 144) - as Victor had tried to explain.

With Rosalinda continuing to hide from the health professionals at the clinic, Doctor Jeanette took the decision to involve the local authorities. Just as pressure was exerted upon Milagros's husband by the local Police when she refused to travel to Lima, as I documented in Chapter 3, so Jeanette called upon the Community President and the Mayor, Chiara's authority figures, to intervene when Rosalinda continued to evade the attentions of the *Posta* staff. Accordingly, late one afternoon, Rosalinda and her family were visited at home by a delegation made up of Doctor Jeanette; Juan Antonio, the obstetrician; Mercedio, the community President and the Mayor. I was invited to accompany them on the visit.

We found a heavily pregnant Rosalinda sitting in the yard with several of her children, feeding a lamb with milk from a baby's bottle. Whilst the lamb continued to drink the milk hungrily, Doctor Jeannette explained the reason for the visit. Due to Rosalinda's continued refusal to cooperate with healthcare professionals, she had no option but to involve the Community authorities. Doctor Jeannette, from Lima, spoke in Spanish to Rosalinda. I had never heard Rosalinda speak Spanish, other than a few greetings as she acknowledged people she passed when walking around the village. Rosalinda thus ignored the doctor, and continued to feed the lamb. Juan Antonio then knelt down in front of her and spoke to her in Quechua. Rosalinda replied in Quechua, shrugging her shoulders. Juan Antonio asked her where her husband was. Victor, her husband, came out of the house and stood by his wife. The Mayor began to speak in Spanish to him, reiterating that Rosalinda must travel to the clinic. Victor responded that he could not make his wife do something that she did not want to do. The Mayor sighed and said that in that case he "had no choice". He then produced some papers from his jacket and handed them to Victor. The doctor took out her mobile phone and began to record the scene, simultaneously declaring in a loud voice in Spanish:

⁹³ Since 2012, the SIS insurance package now also covers the expenses of the accompanying spouse,

“We are recording this because Rosalinda and Victor are refusing to cooperate. The Mayor is asking them to sign some papers accepting responsibility should anything happen to his wife or unborn child as they have refused all medical care”.

The papers were then signed by Victor and Rosalinda, the doctor and Juan Antonio, the obstetrician. They were then witnessed by the Mayor and President. The Mayor said he would take them to be filed in the Community records and the doctor asked for a copy for the health records held at the *Posta*. We then left Rosalinda’s house, with Juan Antonio asking her to reconsider her actions.

Health professionals considered Rosalinda’s continued ‘non-compliance’ to be a fairly typical reaction of rural Andean women in Chiara and the outlying communities served by the Clinic in Izcuchaca. Health professionals regularly commented to me that some pregnant women in remote villages would fail to inform clinicians that they were pregnant and avoid receiving antenatal care. As Victor stated, the women believe that they simply do not need the expertise of the health professionals as they know how to give birth. The women’s decisions to forego antenatal care were also due to a lack of education according to the health professionals. Janeth, an experienced MINSA trained obstetrician working in the clinic in Izcuchaca whom I shadowed closely during my field research commented:

“...according to the (educational) level that they have, they aren’t going to come (to the clinic). They hide the pregnancy. Very few have come to give birth here during this time but they hide their pregnancies all the time. In Actahuasi recently there was the case of a young girl of 16. She didn’t tell anyone, absolutely no one, that she was pregnant. She went to school just the same, apparently everyone noticed she had put on some weight but no one thought twice about it. She complained of colic and her family brought her here, the doctor checked her over and she was ...full term. The family made a real show, they cried, her parents threw themselves on the floor because they just couldn’t believe it...”

Janeth attributes the teenage mother’s failure to inform anybody that she was pregnant to her low educational level, also drawing upon the low socioeconomic status of her

although in 2010 during Rosalinda’s pregnancy this was not the case.

family in Actahuasi, an impoverished rural community, to explain her risky behaviour. Following De Zordo (2012), Janeth's comments betray once again how many health professionals in the course of their medical practice seek to discipline low-income women's sexual, contraceptive and reproductive life by stigmatizing those, - like Rosalinda, or the young pregnant girl in Actahuasi - who do not embody it. Obstetricians also commented that women regularly failed to keep their antenatal appointments in both Chiara and Izcuchaca. I would often accompany them on home visits as they tried to monitor their patients' pregnancies. Janeth, believed firmly that her work revolved much more around home visits than sitting behind her desk:

“Our work as primary care givers is much more to do with going out into the communities rather than sitting here waiting for the patients to come to us because they aren't going to.”

However, clinicians in Chiara also reported that pregnant women would hide from practitioners if they attempted to visit them at home. They would also lie about their due date in an attempt to avoid having to travel to Huancaray two weeks before giving birth. Alternatively, they would “disappear” around their due date, usually having travelled to stay with family in Andahuaylas to avoid having to stay in the *Casa Materna*. For clinicians, rural women like Rosalinda are thus turned into problems because they do not conform to expected norms of behaviour. Such women do not attend clinics when they should; they do not want to give birth in clinics; they place medical professionals in difficult situations as health staff try to ensure that maternal health guidelines and policies are followed. For many clinicians⁹⁴, the actions of their patients are due to irresponsibility, ignorance or stubborn, wilful or manipulative behaviour (Bridges, 2007; de Zordo, 2012). Such attitudes are cited in the work of Khiara Bridges (2007) who in her research in a New York public hospital describes the role of the ‘wily patient’: a patient who health staff classify as stupid yet at the same time are cast by health professionals as “fantastically shrewd manipulators” of the system. Rosalinda and women like her refuse to participate in their own maternal healthcare by attending the clinic for antenatal appointments. Yet health professionals

⁹⁴ The majority of health professionals I interviewed shared this opinion. However I will present the viewpoint of another Doctor who challenges these opinions in Chapter 6.

simultaneously cast them as manipulators able to exploit the system for their own purposes. Thus, like the “obtuse, backwards and altogether unintelligent” female, low-income patients living off the welfare state, which health workers describe to Bridges’ in her study, health personnel in Chiara view Rosalinda and her fellow *chiarinas* as using their reproductive abilities to their own advantage. They assert that ignorance causes them to reproduce and they are able to capitalise on this receiving their monthly allowance through the *Juntos* programme as a reward for their capacity to produce children. For example, Lisbet, a 26-year-old nurse who completed her SERUM, a year of obligatory rural service⁹⁵ in Paucartambo,⁹⁶ spoke to me about this unintended consequence of the *Juntos* programme:

“For me (*Juntos*) has been a stupid idea, because the more children (the women) have, the more money they receive. And they don’t even use it for the children. They receive the money and – at least in Paucartambo – one man used to receive his money and he would use it to buy food for his llamas, food for his livestock. Nothing for his children: they would continue malnourished, pushing up the birth rate”.

As Lisbet suggests, it is also true that not all recipients enrolled in the programme in Chiara used their money to feed their children. The days that the *Juntos* officials visited Chiara to give out the monthly payments usually coincided with market day in the village. Many *chiarinos* would go directly to the market stalls set up in the main square and make food purchases from the stalls with their newly acquired money (see also Cookson, 2016). However, on one occasion, I witnessed other men and women crowd around a newly arrived, self-confessed *curandero* (healer) who was peddling a collection of ‘alternative medicines’ from the back of his car. As the man loudly proclaimed the benefits of his medicines with the help of a microphone, I saw both men and women enthusiastically handing over their 100 soles from *Juntos* to purchase the medicines. The young man standing next to me handed him 100 soles for a box of Chinese Ginseng tea sachets, accompanied by a flier complete with diagrams, detailing how the ‘medicine’ was to be used to bathe in, to effectively treat vaginal infections.

⁹⁵ Chapter 6 discusses the SERUM: *Servicio Rural y Urbano Marginalizado* in more detail

⁹⁶ Paucartambo is a rural village located approximately three hours from Cusco.

Despite assertions from health staff that women like Rosalinda effectively got pregnant solely to obtain money from the *Juntos* programme which they then misspent, one thing that struck me was that at no point did I ever hear any clinician ask Rosalinda for her opinion or simply ask her why she did not want to travel to Huancaray to give birth. It is to the opinions and perspectives of community women such as Rosalinda that I now turn to, in order to gain a deeper understanding of the reasons that underpin their maternal health choices.

‘Good’ and ‘Bad’ Mothering: *chiarina* women’s perspectives

As Rosalinda’s pregnancy progressed and she continued to evade the attentions of the health professionals in Chiara, her behaviour came to be increasingly commented upon in conversations between village members. Local shopkeepers, neighbours, fellow mothers and prominent community members all seemed to have an opinion about Rosalinda and were keen to voice it. Generally, the *chiarinos* were not in agreement with Rosalinda’s actions, although their understanding of her actions, and the reasons why they disagreed with them differed considerably from those of the health professionals.

During a visit to the local shop to buy credit for her mobile phone, Doctor Jeanette is drawn into a conversation about Rosalinda with Luisa, the shopkeeper. Luisa initiates the conversation by telling the doctor she has just found out that Rosalinda is pregnant. Luisa says Rosalinda is irresponsible and putting her own life and the life of her unborn baby at risk. Luisa says that Rosalinda should use contraception to avoid getting pregnant. The doctor responds saying she is very concerned that something will happen to risk the baby’s life. Luisa continues, drawing upon the story of another woman from Chiara – whom she does not name - to indicate that she agrees with the doctor. Ten years ago, before the current *Posta* was built⁹⁷, the woman in question refused to go to the clinic in Huancaray. Luisa tells the doctor that everyone tried to tell this woman that she should go to Huancaray for her own safety and that of her child. The unnamed woman did not listen. The town authorities tried to persuade her: the Mayor, the Governor and the Community President. She did not listen and her

⁹⁷ Prior to the building of the current *Posta de Salud*, there was an old adobe house in the same location serving as a very basic clinic for the *chiarinos*. This building is now the staff living quarters behind the new clinic.

family did not want her to go. Luisa recounts that the woman and her husband signed a waiver form indemnifying the *Posta* should anything go wrong, as Rosalinda and Victor had been made to do. The woman's husband said he would take responsibility if the baby or his wife died. The woman went into labour early and one of the baby's arms and legs could be seen hanging from the woman's vagina. By the time the woman got to Huancaray⁹⁸ the baby was dead. Then the woman cried and regretted her decision because the woman had wanted a son. The baby that died was a son and to this day she has only daughters.

The narrative recounted by Luisa is important for several reasons. Firstly, it closely echoes the steps that were subsequently taken by the Community authorities to pressure Rosalinda and her family to attend the clinic and agree for her to travel to Huancaray to give birth as I have shown above. Secondly, in recounting this narrative, drawing upon the experiences of another woman, Luisa is thus indicating to the doctor that she is in agreement with the current dominant medical and institutional narratives surrounding maternal healthcare. The use of the unnamed woman in her story allows her to position herself as a supporter of the health professionals' stance, whilst simultaneously permitting her to criticise Rosalinda without having to specifically refer to her by name. Luisa uses the anonymous woman in her narrative to draw implicit parallels with Rosalinda's situation. In this way, Luisa is able to portray Rosalinda as an example of a bad mother. The tragic ending of the story lends weight to Luisa's words and justifies her opinion that Rosalinda is irresponsible and putting her baby's life at risk. Luisa ends her narrative stating she is "worried for her". Luisa attributes Rosalinda's troubles to wider socio-economic concerns: Rosalinda has too many children; they are all malnourished and *chiquitos* (tiny). The house is too small for them all, they all sleep in one room and her husband is a *machista* (sexist). "Poor woman", she repeats over and over. She tells the doctor she will go and visit her the following day and try to persuade her to go to Huancaray.

Thirdly, the story is important because it shows us clearly that Rosalinda is not the only woman in Chiara to have decided not to follow the norms expected by the Ministry of Health regarding maternal health provision. Luisa's narrative underlines that there are other women who have chosen to disregard the directives of the MINSA

⁹⁸ Huancaray is two and a half hours away from Chiara by public transport.

policy and continue to give birth at home. Her narrative thus serves to illustrate the opinions, experiences and perceptions of rural women, who like Rosalinda have chosen to resist *parto institucional* (clinically managed birth). Indeed, in the telling of her story, I noted that Luisa was extremely careful to ensure that the pregnant woman referred to remained anonymous: it is likely that the woman still lives in Chiara. Luisa does not want to disclose her identity to the doctor because in so doing, Luisa would be naming another woman like Rosalinda who refused to accept the norms of current maternal health policy. She situates the story in the past, “10 years ago” before the current policy advocating obligatory (in Chiara) institutionalised birth was in force, thus further ensuring the woman is freed from any potential difficulties with the health professionals, such as the payment of a fine for giving birth at home or incurring sanctions levied by the *Juntos* programme. Luisa’s insistence on anonymity indicates that there is a tension between the general policy dictates which health professionals must enforce and their application in local context. As my research progressed this tension became ever more evident as I tried to speak specifically to the pregnant women the policy affected, to better understand their points of view.

I began by trying to speak to Rosalinda herself which proved difficult on several levels. Rosalinda’s daily routine, like that of many *chiarinos*, began at dawn when she would lead her goats and sheep away from the village and out to pasture. She would thus be away from the village for extended periods of time. When at home, she had many domestic chores to attend to: washing clothes, cooking and keeping house, all of which occupied her time fully. Further, Rosalinda’s first language was Quechua of which I only spoke some rudimentary phrases – greetings and basic requests. She did not speak enough Spanish to allow us to communicate beyond basic greetings. Victor, her husband did speak Spanish and I tried to arrange to speak to the couple together so that he could translate, however Victor’s work as a musician often meant he was away from home for extended periods of time and Rosalinda made it clear that she would not talk to me without her husband being present. As time progressed, and I got to know the family more, Victor would greet me cordially in the square and exchange pleasantries with me. His mother invited me for breakfast and we spent half an hour eating rice and egg and drinking the sweet sugary camomile tea beloved of the *chiarinos*. Throughout the meal, Victor’s mother smiled and chatted animatedly with me in Quechua and I smiled and chatted back in Spanish neither of us really

understanding what the other was talking about. The family did not want me to bring a translator to the house because they did not want to discuss the situation with another *chiarino* present. Eventually, I came to accept that Rosalinda simply did not want to discuss her pregnancy with me and neither did I want to bother her or risk upsetting her unnecessarily.

Although I was thus never able to speak to Rosalinda personally to ascertain her reasons for continually refusing to travel to Huancaray to give birth, her story nevertheless functions as a heuristic device to reveal core issues at stake for women and health professionals in Chiara. Her actions make clear that at stake for her are everyday pragmatic concerns such as child care, agriculture, cattle rearing and housework, which override the logistics of travelling to a clinic to give birth. However, health professionals are more concerned with ensuring that rural women follow the policy norms. Further, because sanctions can be forthcoming for both parties if the norms are not followed (as exemplified in Chapter 3), both parties tend to distrust the other. Hence, the doctor calls on the wider village authorities to act because she does not trust that Rosalinda will agree to give birth in an institutionalised setting given her previous history of home births. Similarly, patients distrust the health professionals, fully expecting them to report them to *Juntos* for breaching policy norms. Such fear of economic sanction or public reprisal means that many pregnant women are too afraid to speak out and voice their true opinion. In response, women like Luisa will openly appear to endorse the maternal health programme in operation in front of health professionals, publically expressing their disapproval of the actions of women such as Rosalinda, yet are simultaneously reluctant to discuss their own experiences lest they draw attention to themselves, arouse the anger of the health professionals and, in turn, become sanctioned by the Ministry of Health working in conjunction with *Juntos*.

Further, while initially it had appeared to me that women in Chiara supported the current maternal health policy, we can see that their support is conditional upon the circumstances in which they find themselves. As stated, in their conversations and meetings with the health professionals, women will readily endorse the current policy.

However, during their conversations with family and friends, - or with me⁹⁹ – they expressed very differing views. There is thus a clear disjuncture between what *chiarina* women express regarding maternal health provision when meeting with a health professional or with acquaintances, and what they truly think, thoughts which are articulated only amongst trusted company.

This concern to be seen to endorse maternal health policy, particularly when under the gaze of medical authority, often lead *chiarina* women to present an idealised image of motherhood, most notably in the presence of the health professional. Even so, *chiarina* women were equally careful to present themselves as ‘good mothers’ when out and about in the community (see also Murray de López, 2016, on fetishized ‘good mothering’ in Mexico; de Zordo, 2012, on presenting oneself as a ‘good’ mother in Brazil). ‘Good mothers’ in Chiara are defined – by both health professionals *and* the women themselves - as those who comply with the norms of maternal health policy. As I have shown in Chapter 3, Isabela was not removed from the *Juntos* programme despite missing several meetings because she was prepared to declare in front of practitioners and neighbours that she would respect the rules of the programme in future. ‘Good mothers’ in Chiara therefore attend their antenatal appointments regularly and agree to give birth in clinics. Or like Isabela, they are mothers whose wayward behaviour can be modified and brought back into line with institutional norms. ‘Bad mothers’ are those who – like Rosalinda – fail to comply¹⁰⁰.

Luisa positions Rosalinda as a ‘bad mother’ for her failure to conform to expected norms. Having positioned her as a ‘bad mother’, Rosalinda then becomes a target for idle gossip as Luisa questions her mothering abilities: she has “too many children” and they are “too small and malnourished”. Luisa’s words imply that Rosalinda, in her capacity as a ‘bad mother’, fails at carrying out expected social roles. Motherhood in Chiara thus becomes positioned as a moral experience (Kleinman, 1998) drawing in ordinary people as “deeply engaged stakeholders who have important things to

⁹⁹ Milagros’s views on her childbirth experiences recounted to me in Chapter 3 criticise the actions of the doctors, nurses and wider local authorities. She never openly discussed her experiences when out in the Community, but was willing to do so in private within the confines of her own home.

¹⁰⁰ Anthropologists have widely explored the concept of ‘bad mothering’. See Nancy Scheper-Hughes (1993) for a discussion of bad mothering in Brazil’s shanty towns; Anna Tsing (1990) for an analysis of bad mothering amongst American women charged with endangering the lives of their babies by having unassisted births; Linda Whiteford (1996) for a political and economic based analysis of bad mothering amongst drug-addicted pregnant women; Cecilia Van Hollen (2003) on bad mothering in

lose, to gain and to preserve” (Kleinman, 1998:8) as they negotiate the intricacies of maternal health provision in Chiara and vie to preserve their own health citizenship.

Mariana’s Birth: reinforcing the punitive message

Rosalinda’s pregnancy ended in the early hours on a Wednesday morning when she came to the *Posta de Salud* in labour, accompanied by Victor, her husband, and her mother-in-law. The health professionals had not expected her to come to the clinic to give birth given that she had asserted throughout her pregnancy that she was not going to do so. Nevertheless, at 2am, I was woken by the voices of Juan Antonio and Inés talking rapidly and excitedly in the defunct delivery room next to the patient ward in which I slept. Bleary eyed, I climbed out of bed to discover why they were in the *Posta* at such an early hour. Learning that Rosalinda had arrived at the *Posta*, I left Juan Antonio and Inés putting on their scrubs and sterilising surgical instruments. I went through to Juan Antonio’s consultation room where I found Rosalinda, Victor and his mother standing around looking uncertain about what to do. I greeted them all, Rosalinda nodded at me and Victor smiled. Juan Antonio came through and asked me to go outside, where the mobile phone signal was stronger, and call an ambulance from Huancaray to come and collect Rosalinda. I made the call and Arturo, the Director at the clinic in Huancaray said he would dispatch the ambulance but it would be some three hours before it would arrive. Whilst I was making the call Inés came outside and said loudly:

“That woman is still refusing to cooperate. She won’t sit on the bed. Sooner or later though, she will have to open her legs”.

Back inside, Rosalinda was standing by the bed supported by Victor. She would not speak to anyone. She showed no sign of being in labour other than an occasional grimace. We all stood around looking at each other. I noticed that Victor’s mother was carrying a woven bundle. I asked her if it was the *manta* (blanket) used to stand on when giving birth. She nodded and unwrapped it, removing some baby clothes from inside. I looked at Juan Antonio. He sighed and said, “Mama Rosa, do you want

India; Christa Craven (2005) writing on Home Birth Mothers and their interactions with the state in the USA and Karen McCormack (2005) on the supposed irresponsibility of the ‘bad’ welfare mother.

to do this standing up?” Rosalinda nodded. Juan Antonio looked at me and said “I’ve never attended a vertical birth before”. Rosalinda, Victor and his mother laughed. Juan Antonio placed the blanket on the ground and Rosalinda stood astride it, having encased her feet in surgical slippers at Juan Antonio’s insistence. Victor’s mother announced she was going home to make coffee because this helped Rosalinda give birth quickly. She returned ten minutes later and everyone drank coffee. The atmosphere was now more relaxed: Juan Antonio was smiling and said to Rosalinda that she should indicate when she wanted to push and he would put his gloves on and he and Victor would help her give birth. She ignored him. Five minutes later, she clutched the side of the bed with one hand and Victor said “now”. Rosalinda grunted and Juan Antonio, still without his gloves on, bent over. Almost immediately he stood upright cradling the newborn in his arms. After the birth, once Rosalinda was settled in the patient’s room, I was dispatched to call Huancaray and cancel the ambulance.

The following day, Rosalinda and her daughter, Mariana, received a stream of visitors in the *Posta*. All of Rosalinda’s children visited periodically throughout the day and took turns carrying their sister in their arms. Many of the *chiarinos* came to congratulate her and admire the baby. By the early evening, the *Posta* staff had convened an emergency meeting to be held at the *Posta* and to be attended by all families enrolled in the *Juntos* programme.

Such were the number of attendees that the meeting spilled out onto the pavement outside the *Posta*. Everyone had heard of Mariana’s birth and was keen to hear what Juan Antonio had to say. Victor was amongst the men in the crowd. Juan Antonio chaired the meeting. He did not waste time in getting to the point. Acknowledging that Rosalinda had given birth in the *Posta* in the the early hours of the morning he underlined that this was not to be seen by the *chiarinos* as a precedent. He reiterated that all births would continue to be attended in Huancaray. Anyone intending to flout these rules would be sanctioned accordingly. He made it clear that Rosalinda and her family would now be struck off from the *Juntos* programme losing their monthly payment until further notice. Rosalinda would have to pay the required financial fine for giving birth in Chiara not Huancaray. He underlined that Mariana’s birth at the *Posta* would be viewed as problematic by the Regional Health Authority. He expected a full investigation to be launched. He and the other health staff had been placed in a very difficult situation because of the birth in Chiara. The *chiarinos* were now also in

a difficult situation as questions would be asked of their authority figures: the Mayor, the Community President and the Governor.

The events that followed the birth of Mariana reinforce the punitive message that women will be sanctioned for failing to give birth according to the established norms. Through the application of the norms governing the *Juntos* programme, women in Chiara are told *when*, *where* and *how* they must give birth: they must stay in a *Casa Materna* up to two weeks prior to their due date; they must give birth in a particular specified clinic – in this case Huancaray; and they must give birth in an institutionalised setting with obstetric staff present. Whilst Rosalinda refused to travel to Huancaray, she did however finally succumb to pressure exerted upon her and her family and gave birth in the clinic in Chiara, located minutes from her home. Nevertheless, she was still sanctioned as she had not given birth in the correct clinic, nor followed the required antenatal procedures. In drawing specific attention to the birth of Mariana at the *Posta* in Chiara, Rosalinda is used as a ‘teaching aid’: Juan Antonio uses her story as an example of a “bad mother” in a hastily convened public meeting to remind *chiarina* women of the rules they are required to follow when giving birth.

In addition, aside from the biopolitical interventions brought to bear, Rosalinda’s story shows us that the way in which current maternal health policy is applied in Chiara causes pragmatic difficulties for the women and their families it is intended to support. Rural women perceive clinically managed birth as problematic until relatively recently they have given birth at home. Rosalinda’s actions, and the actions of other pregnant community women such as the anonymous woman in Luisa’s story, are grounded in pragmatic concerns. As Victor attempted to explain to the nurse, the organisation of family life makes it difficult for Rosalinda and her rural counterparts to attend the clinic in Huancaray to give birth: family and work responsibilities within Chiara mean that current maternal health policy is simply impractical for many rural families in the Andes. At stake for Rosalinda and her family then, is how to reconcile the realities of family life with the demands of maternal health policy, which fails to take into account the cultural complexities of daily life and the structural issues – such as grinding poverty, gender inequalities and the political economy – within which pregnancy and birth are enmeshed.

Pregnant women in both Chiara and Izcuchaca recounted similar difficulties to those that Rosalinda and her family encountered. Mariana's birth provided the opportunity to converse with other women in Chiara, as the women were keen to discuss the events surrounding Mariana's birth and relate them back to their own childbirth experiences. I was thus able to draw upon a wider range of study participants than previously. Once again, the women agreed to talk to me on condition that I did not disclose their opinions to the *Posta* staff or representatives of *Juntos* for fear of reprisals as I have documented. Rural women frequently cited pragmatic and practical reasons such as family responsibilities; housework; child care; animal grazing and agricultural responsibilities; economic expense and time as central reasons to explain the difficulty in attending the *casa materna* to give birth. For example, Isabela, the woman whom Juan Antonio publically berated in the public health *charla*, (as noted in Chapter 3) told me that in 2006 she chose to give birth in her *choza*, a rudimentary shelter constructed of straw and mud brick on the agricultural land she worked. Her reasons for doing so were largely influenced by her concern for her other children's welfare should she travel to Huancaray to give birth:

Isabela: "I was going to go down to ... to give birth in Huancaray. I was afraid though; whom was I going to leave my children with? I couldn't go down to Huancaray. I had to be here with my children. So I couldn't go. I went to the *choza* to care for my animals as normal ...when I was gripped with pain and I didn't want to go and tell anyone. By nighttime it was worse, there was more and more pain and I was in labour. My husband said to me "You are going to take your things (to Huancaray)" and I didn't want to. When I came back (from the *choza*) ...when I came back, I had my appointment for my check up. Well I had already given birth by then in the *choza* so they told me I would have to pay a fine. When we said, "But you knew I was due around now" they said that was why I had to pay a fine. They were going to make me pay...

Maria: And in the end did you have to pay?

Isabela: Yes. At the end of the day, it's simple. They make everyone pay who gives birth at home... if they give birth they always have to pay the fine. So because of that, I had to pay too. They made me pay for giving birth here; they made me".

Simultaneously, many of these same women also recognised the importance of potential medical intervention in childbirth to guarantee their safety and the safety of their unborn child. Isabela's subsequent births in 2007 and 2009, both took place in Huancaray. Despite having suffered a stillbirth in the *Posta* in 2002, a fact which also

influenced her decision to give birth in her *choza* in 2006, Isabela acknowledges that had she not been in the clinic in Huancaray for her fourth birth in 2007, that baby would also have died:

“With her, had I not gone to Huancaray, if I had given birth at home, (my daughter) would have died because the staff there helped me”.

What greatly matters for local women like Rosalinda then, is how to reconcile the demands of maternal health policy within the routine of their everyday lives. Attending a clinic to give birth is in itself not problematic, but the everyday practicalities of travelling to and staying at a medical establishment located several hours from their home raises many pragmatic difficulties. To do this, they must use public transport that is at best infrequent and at worst unsafe. Once at the clinic or *Casa Materna* they are expected to stay for several weeks until they give birth. Whilst there, they have also to balance the demands of their everyday lives from a distance. Pregnancy and birth in the Andes cannot therefore be viewed as a simple division between supposed cultural explanations (such as their preference for home birth) and biomedical clinical ones (such as the promotion of clinically managed birth). As I have shown, rural women have much more pragmatic reasons for acting the way they do. There are good reasons for their practices, particularly those that are perceived by health professionals as ‘bad’. Moreover, obligating community women to travel to clinics away from their home also removes their familial support structure upon which they rely.

Elena, one of the community women that I came to know very well, wanted to travel to Andahuaylas to give birth in the hospital there so she could be near to her family. The obstetrician working in the *Posta* at the time told her that this would not be a problem. However, the Doctor at the *Posta* insisted that she must give birth in Huancaray, the nearest health facility to Chiara, in line with policy requirements. Upon arriving in Huancaray, Elena decides to run away to join her family in Andahuaylas. She recounted the circumstances behind her decision to me one afternoon as we sat outside drinking *mate*, a local tea:

Elena: “From here I went by taxi down to Huancaray with my husband and with the Doctor, the Doctor too. Then when I was there they tried to make me stay “You have to stay here. You can’t go to Andahuaylas,” they were telling me. My husband argued with them, so at night we went to Andahuaylas. “I’m going to Andahuaylas” I said, “I don’t have any family here.” So we got in a taxi and we went to Andahuaylas.

Maria: “Leaving the Doctor in Huancaray?”

Elena: “Yes. Aha. He caught up with me further down the road. It was Doctor Juan Carlos. He’s a good person. He caught up to me in the square in Huancaray. “Hey Elena, you have to look after yourself, you have to go to the hospital. Make sure you go”. He told my husband as well. “Make sure you look after her”, he said to my husband. He caught us up, running after us. “You really can’t stay in Huancaray? Are you sure you have family in Andahuaylas?” he was saying. So we went by car to Andahuaylas”.

Elena’s narrative clearly illustrates the pressure she felt and the difficulty posed for her once her family support structure was removed¹⁰¹. Elena is not against giving birth in a clinic *per se*, but wanted to be near her family. Inflexible policy constraints forced her to take matters into her own hands and ‘run away’. Elena, like Rosalinda and other community women, find the constraints of maternal health policy difficult to reconcile with the demands of their daily lives and their traditions.

Conclusion

This chapter provides a vantage point on the routine and everyday experience of what it means to be pregnant and have a child in Chiara today. Focusing on women’s lived experiences of maternity as ‘moral experience’ (Kleinman, 1999a; 1999b; 2006), helps us to understand what is at stake as women, their families, friends and neighbours, health professionals and local authorities negotiate the intricacies of Peru’s current maternal health policy requiring that Andean women deliver in a health establishment.

Closely following Rosalinda’s actions and the reactions of those around her from the discovery of her ninth pregnancy through to the birth of her daughter reveals differing perspectives and expectations coalescing around maternity and motherhood. At stake

¹⁰¹ I discuss the importance of familial involvement in pregnancy and birth in more detail in the following chapter.

for rural women living in an isolated highland community, is the possibility of being able to carry on with the daily routine of their lives largely uninterrupted by their pregnancy. Fulfilling their child care responsibilities, continuing to manage the organisation of the family home, tending to their livestock and crops, being surrounded by their family in the final days of their pregnancy and at the birth of their child; all are important factors influencing their maternal health decisions.

When Rosalinda and her rural counterparts do not conform, institutionally constructed discourses built around ideas of ‘good’ and ‘bad’ mothering come into play. Health professionals view it as their “moral and civic duty” (De Zordo, 2012) to persuade women who do not follow expected reproductive trajectories to modify their behaviour. Women like Rosalinda; - mothers to large families living in poverty - are regarded as ‘irresponsible’ for their failure to limit their family size in line with their socio-economic means (de Zordo, 2012). When they refuse to cooperate with practitioners, they are viewed as displaying wilful and stubborn behaviour (de Zordo, 2012) and judged by practitioners to be a moral risk (Chapman 2006; Gálvez 2006; Smith-Oka 2012a). Regarded as manipulative patients (de Zordo, 2012; Bridges, 2008), they are also ‘bad mothers’ whose ‘bad’ behaviour must be changed.

In Chiara, ‘good mothers’ attend their antenatal appointments, stay in the *Casa Materna* and give birth in the clinic in Huancaray. Women, like Rosalinda, who do not, are economically sanctioned and publicly berated by Ministry of Health employees to reinforce the punitive message. The ‘biopolitics of reproduction’ (Waldby and Cooper, 2008) at play in Chiara draws the local community into the biopolitical process: in Rosalinda’s case we see local women like Luisa deflecting attention away from themselves by appearing to support the dominant medical and institutional narratives in Chiara, whilst when outside of the medical gaze, they may not wholly agree with the policy initiatives. In addition, the local authorities of Mayor, Community President and Governor are drawn upon to ensure the compliance of women like Rosalinda who, in avoiding antenatal interventions, continue to exhibit ‘risky’ behaviour.

However, such perceived ‘risky behaviour’ and ‘non compliance’ of rural women is often underpinned by pragmatic concerns: the pressures of balancing day-to-day life and familial responsibilities with the difficulties inherent in accessing maternal

healthcare. Maternal health provision and delivery cannot therefore simply be construed as a cultural issue as the Ministry of Health presents the problem. Rather, it must be understood in light of the local context and the specific and often pragmatic concerns in which it is embedded. Often, women like Rosalinda have very good reasons for their ‘bad behaviour’. They, like the health professionals who care for them, find themselves enmeshed “in particular circumstances and in cultural conditions where the things that matter most to them have been challenged by what is at stake for others” (Kleinman, 2006:294).

As I have shown in this chapter, in determining ‘what really matters’ to them during pregnancy and birth, the actions and reactions of both patients and practitioners on the ground are informed by moral experience. In the following chapter, I move away from pregnancy and birth grounded within a community setting, to investigate *parto institucional* (clinically managed birth), in Ministry of Health run clinics. In so doing I discuss the importance of family dynamics in maternal health decision making, and the vulnerability of women who without familial support succumb to instances of obstetric violence, exploring how the trauma of separation from family at birth becomes embodied in *post partum* illness.

Chapter Five: Ties that bind: Family and *Parto Institucional*

Introduction

Through the telling of Rosalinda's story in the preceding chapter, I discussed how pregnancy is positioned as moral experience showing 'what is at stake' for those in question (Kleinman, 2006). Health professionals regard it as their 'civic duty' to encourage Andean women to give birth in clinics, disavowing them of their 'erroneous cultural suppositions' that favour home birth. Both practitioners *and* community members encourage Andean women to conform to institutionally constructed ideas of 'good' motherhood in Chiara: 'good' mothers have a 'moral duty' to give birth in Ministry of Health establishments. In order to achieve this, family and community members are responsabilised to ensure the *gestante* (mother-to-be) attends her antenatal appointments and agrees to a *parto institucional*: a clinically managed birth. This chapter builds on Andean women's experiences of pregnancy recounted in Chapters 3 and 4, to extend understandings regarding the importance of familial involvement not only in pregnancy but also crucially, at delivery in state run clinics. Drawing upon the narratives of three Andean women, I show how familial presence or absence during pregnancy and birth has far reaching impacts upon positive maternal health outcomes; influencing women's embodied experiences of birth, and perceptions of their own fertility.

The chapter begins with Jessamyne's story: a young first time mother-to-be. As I will show, Jessamyne represents the 'model' patient for the Ministry of Health: fully cognizant of her maternal 'responsibilities' and able to draw upon the support of her family throughout her pregnancy and upcoming birth. Her *suegra* (mother-in-law) in particular, is a vital emotional and moral support for Jessamyne, encouraging her to agree to a clinically managed birth, details of which are recorded via MINSA's Delivery Plan. Discussed and completed over time during routine antenatal appointments and home visits, I show how MINSA harnesses Delivery Plans, promotional imagery and published newspaper reports to encourage family members to actively engage with clinically managed birth.

However, Violeta and Milagros's stories, recounted in the subsequent sections of this chapter, reveal different perspectives on clinically managed birth when familial support is absent or withdrawn. Violeta's admission to hospital for an emergency caesarean brings to the fore concerns surrounding familial decision making processes, at odds with institutional expectations in situations requiring Emergency Obstetric Care (EmOC). Her story also highlights that women, when separated from family members at delivery, become vulnerable to instances of Obstetric Violence (OV) in state run clinics, violence that – as Violeta's case shows – effects their future fertility. Milagros's narrative highlights how the disjointed organisation of the public health system, as patients are referred up from one health establishment to another, impact upon her perceptions of delivery. As she becomes enmeshed in the fractured nature of the system, Milagros struggles to come to terms with her traumatic delivery, felt all the more keenly as she is forcibly separated from her family. Her trauma becomes embodied as *post-partum* illness, as she fails to reconcile her bodily experiences with any positive perception of what future pregnancy and birth may entail. The chapter ends critiquing MINSA's policy of *parto institucional* and discussing the implications for Andean women and their families when giving birth in institutionalised settings in Peru today.

Jessamyne: A model *gestante*

When I met Jessamyne she lived with her husband, David, and his family: his parents, his brother and his sister-in-law. Jessamyne and David had begun their relationship as teenagers and had decided to marry last year, when both were 19. Despite being married, David and Jessamyne had decided to delay starting a family until they were older and until such time as they could afford to live independently in their own home. However, Jessamyne had recently discovered that she was unexpectedly pregnant with their first child.

The extended family lived in a large mud brick house on the outskirts of Izcuchaca. The house is some 25 minutes walk from the clinic and is surrounded by a large and

well cared for garden. I visited Jessamyne at home, accompanying Janeth¹⁰² on her weekly round of obstetrician's Home Visits¹⁰³. Today was Janeth's turn on the Home Visit Rota, and Jessamyne was on her list. When we arrived at the house, Janeth called out Jessamyne's name and we waited in the garden, admiring the abundance of flowers, fruit and vegetables growing in the family plot. Jessamyne came out of the house, smiled and greeted us and asked us to sit on some large stones strategically placed in the garden for use as seats. She apologized for not inviting us inside, explaining that it was the house of her *suegra* who was not presently at home, and so she felt it was not her place to invite us inside. We chatted to her for approximately 20 minutes, while Janeth asked her questions about her everyday health during her pregnancy, and discussed her Delivery Plan¹⁰⁴ (Figure 23). The Delivery Plan is used to record the *gestante's* choices of how she would like to give birth, - whether on a gynaecological bed or chair, or, as is traditional in the Andes, using *parto vertical* birthing techniques. In addition, the Delivery Plan also records which family members will be present, and how the *gestante* will arrive at the clinic to give birth: on foot, by public transport or other means. The Plan also details danger signs to look out for during pregnancy and warns the patient to come immediately to the clinic at the first sign of danger.

Jessamyne answered all of Janeth's questions fully, and was able to list all of the danger signs she was to look out for. Janeth reminded her of the date of her next antenatal appointment at the clinic and Jessamyne assured her she would attend. As Jessamyne countersigned her Delivery Plan, Janeth having already done so, Janeth bestowed a wide smile upon her. She tore Jessamyne's Delivery Plan free from the remaining batch, and with a flourish handed Jessamyne her copy. Turning to me she said, "See? Now that is what we want: a *gestante* who *knows!*" Jessamyne laughed

¹⁰² Janeth is the Obstetrician whom I shadowed most closely in Izcuchaca, observing her appointments with patients both at the clinic and at home and accompanying her as much as possible throughout her normal working day at the clinic.

¹⁰³ Home Visits, or *Visitas Domiciliarias*, are used by Obstetricians at the clinic in Izcuchaca primarily to follow up on patients who have missed a scheduled antenatal check at the clinic. They are also used to check on the wellbeing of women who have recently given birth. The Duty Manager assigns the Home Visit Rota and obstetricians take turns to carry out such visits. Accordingly, in addition to their own patients they may also visit patients under the care of another obstetrician at the clinic.

¹⁰⁴ I discuss the centrality of the Delivery Plan in preparing Andean women and their families for clinically managed birth in the following section of this chapter.

shyly and said, “Did I pass the test?” Janeth responded, “*Sobresaliente*” (With flying colours).


The attending obstetrician, the mother-to-be and a family member are required to sign the Delivery Plan. In this way, the Ministry of Health use the plan as a ‘technology’ to engage the wider family in taking an active role in managing the *gestante*’s maternal health. In specifying on the plan how she is going to arrive at the clinic, Jessamyne must also specify with whom. For women living in isolated rural villages where public transport is infrequent and unreliable, the geographical terrain is challenging¹⁰⁵, and ambulances supplied by MINSA are in extremely short supply¹⁰⁶. Enabling the *gestante* to reach the clinic or *Casa Materna* necessarily involves the ‘recruitment’ of family members¹⁰⁷ to arrange transportation and accompany her on the journey. In Jessamyne’s case, living a short ride from the clinic, she was able to draw upon the services of her *suegro* (father-in-law) who was a registered taxi driver, to bring her to the clinic.

Jessamyne’s Delivery Plan also fulfils a ‘socio-cultural’ function, drawing her family together to discuss her upcoming delivery. Jessamyne told me that she had discussed her birth options at length with both her husband and her *suegra*. Her mother-in-law had always given birth in a clinic and advised Jessamyne to do the same. When I asked her if she would not prefer a home birth she replied:

¹⁰⁵ I discuss the impact of geography and logistics on maternal care in more detail in Chapter 6.

¹⁰⁶ In Chiara there was one ambulance located at the birth clinic in Huancaray. This ambulance had to serve Huancaray, all the outlying health posts in the Regional Health Authority’s designated catchment area, and also transport patients in medical emergencies to Andahuaylas, some three hours drive away. In Izcuchaca, the clinic had two ambulances, again required to transport patients from outlying districts and on to Cusco in medical emergencies.


¹⁰⁷ Or members of the wider community as I discussed in Chapter 3 with the *Maternidad Segura: Compromiso de Todos* (Safe Motherhood: Everyone’s Responsibility) campaign.



ESPERANDO MI PARTO

(PLAN DE PARTO)

Este Plan ayudará a que la mamá se prepare para la llegada del bebé



NOMBRE DE LA GESTANTE: _____

EDAD: _____ HCL: _____ GRUPO SANGUINEO: _____ FPP: _____

DIRECCIÓN (COMUNIDAD, SECTOR, ANEXO): _____









DIRECCIÓN DE REFERENCIA: _____

EE.SS: _____ MICRO RED: _____ RED: _____

TELF. DEL EE.SS: _____ FRECUENCIA DE RADIO DEL EE.SS: _____ TELF DE LA COMUNIDAD: _____

NOMBRE DEL PROMOTOR DE SALUD: _____

TIEMPO QUE TARDA EN LLEGAR AL ESTABLECIMIENTO: _____

INTERVALO PLAN DE PARTO		1ª ENTREVISTA (I TRIMESTRE)	2ª ENTREVISTA (II TRIMESTRE)	3ª ENTREVISTA (III TRIMESTRE)
1	FECHA			
2	EDAD GESTACIONAL			
3	¿Dónde se atenderá su parto?			
4	¿Quién desea que le atienda su parto?			
5	¿En qué posición prefiere dar su parto?			
6	¿CÓMO SE VAA TRANSPORTAR EN EL MOMENTO DEL PARTO O EN CASO DE EMERGENCIA?			
7	¿Quiénes le acompañará o avisará al establecimiento de salud en el momento del parto o presencia de señales de peligro durante el embarazo?			
Aquí le ayudamos como reconocer LAS SEÑALES DE PELIGRO EN EL EMBARAZO para acudir INMEDIATAMENTE AL HOSPITAL:				
Si tienes Vómitos frecuentes:				
Si hay palidez de la cara y cansancio				
Si tienes Calentura (fiebre)				
Si tienes Dolor de cabeza, Visión borrosa (si ves lucecitas) Zumbido de oídos				
Si tienes Hinchazón de Pies, manos o cara				
Si tienes Dolores antes de la fecha de parto Y endurecimiento del vientre.				
Si tienes Poco o falta de movimiento del bebé				
-Si tienes Pérdida de sangre por la vagina -Pérdida de líquido por la vagina -Infecciones vaginales SI EL BEBE ESTA MAL ACOMODADO				
Otras infecciones; tos, diarreas, Infección Urinaria (Ardor al orinar) etc.				
8	¿Quién cuidará de sus hijos, su casa, animales durante su ausencia?			
9	¿Aceptaría ir a la casa materna u otro cerca del establecimiento?			
10	¿Sabe cuándo debe ir a la casa materna?	Si No		
11	Firma de la gestante			
12	Firma de la pareja, acompañante o familiar			
13	Firma de trabajador que realiza la visita			

Para el bebé

Reponido de lana y ropa de algodón
Frazadilla
3 Pañales descartable, tela
Toalla


Para la mamá


Ropa holgada o bata
3 Calzones limpios
1 Paquetito de toallas higiénicas post parto
4 Protecciones de cama
Utiles de aseo


Documentos


1 Copia de DNI de gestante y de la pareja
1 Copia del carnet de control de embarazo
2 Copias de la hoja de afiliación al SIS

SEÑALES DE PELIGRO DESPUES DEL PARTO Y SEÑALES DE PELIGRO DEL RECIEN NACIDO


bebé amantito


Bebé morado


Bebé no quiere lactar


Bebé si baja de peso

SPA/24.8.2015

Recuerda:

1º Control después del parto a los 7 días

2º Control después del parto a los 15 días

El control del RECIÉN NACIDO en el consultorio de niño sano

Figure 23: MINSA's *Plan de Parto* (Delivery Plan): Courtesy of Janeth.

Obstetricians and mothers-to-be complete the plan together during antenatal consultations or Home Visits to establish where, how and with whom the mother-to-be wishes to give birth. The Delivery Plan also details the mode of transport the *gestante* (pregnant woman) will use to arrive at the clinic and who will be responsible for getting her there. In addition, the plan includes a list of danger signs in pregnancy, warning the *gestante* to attend her nearest clinic as a matter of urgency should she experience any of the symptoms. Source: copy given to me by Janeth during a consultation.

“There are too many risks to run, you know, if you give birth at home. And, well, I for one am happy. I have received a good level of care here, so yes, I agree to give birth in the clinic.”

Nevertheless, Jessamyne told me she was concerned that although she had agreed to give birth in Izcuchaca, she had heard rumours that family members - despite what was written on the Delivery Plan – had been refused entry to the delivery suite by obstetricians. Both Jessamyne and her husband were very clear that they wanted to experience the birth of their first baby together:

“... That is what he wants, to be there. We have also checked that ... that... they allow him to be there, you know? ... and he said that: “Oh I hope they let me in”... because of course, if he’s there, I will feel more confident you know?”

I did my best to reassure her, telling her that I had witnessed several births with Janeth attending as the leading obstetrician and in all of them, she had encouraged the birthing woman’s husband, mother, or mother-in-law to not only be present, but also participate where possible, lending emotional and moral support. As Janeth had now left, leaving me alone to speak to Jessamyne, I urged her to reiterate to Janeth at her next antenatal appointment the necessity of having her husband with her at the birth, which Jessamyne said she would do.

The key role of husbands or partners in the decision-making processes regarding women’s antenatal and delivery care is acknowledged as a key factor influencing women’s healthcare-seeking behaviours (Browner, 2000; Lubbock and Stephenson, 2008; Onah, Ikeako and Iloabachie, 2006; Osubor, Fatusi, and Chiwuzie, 2006; Castro et al., 2000; Okafor and Rizzuto, 1994), with women’s husbands’ or mother-in-law’s experiences of maternal health services influencing women’s perceptions and utilization of care in particular (Lubbock and Stephenson, 2008; Sai and Measham, 1992).

Portela and Santarelli (2003) also recognise the centrality of the family in the decision-making processes that take place within households concerning birth. They underline the importance of the pregnant woman having the opportunity to discuss her

Delivery Plan not only with a health professional, but also with her family, arguing that a final feasible birth plan can only be developed after this interaction at the household level (2003:65). They acknowledge that family inclusion may not always lead to the birth recommendation initially envisaged by the health provider, but in involving the family in preparing for birth and obstetric emergency situations, such efforts can lead to a crucial decrease in the delays in decision-making for reaching care when needed and an increase in the use of obstetric services (2003:65). They also underline that familial discussions of birth plans – such as Jessamyne had done – empower the pregnant woman and her family: their choices are based on informed decision-making and the process provides them with capacity to influence and improve maternal health outcomes.

Aside from advising and encouraging her to agree to a clinically managed birth in Izcuchaca, Jessamyne elaborated on how her family had been crucial in helping her adapt to the unexpected news that she was pregnant:

“When I found out I was pregnant, well, I was like any other young person, no? Sometimes we have aims or objectives we want to achieve and so we become quite depressed, you know? And then we realize that nowadays things can be done. In Peru it’s quite common to have an abortion. And ok, you know? And to be honest even I thought about taking that route, but I am married to my husband – we’ve been married a year and a few months – so that gave me security, you know – the fact that I was married to my husband. I spoke to him and he said to me “We are going to carry on moving forward”... the arrival of this baby, well, it has changed my life into something different, no? So the first weeks, the first months ... well... I felt quite depressed you know? I couldn’t get it into my head you know, ... this having a baby thing”.

Whilst Jessamyne initially asserts that it was her husband’s encouragement to look to the future that convinced her to continue with her pregnancy, as she recounted her story, she increasingly referred to her mother-in-law’s influence over her maternal health. For Jessamyne, her unexpected pregnancy had an important social consequence: it significantly altered the dynamics of the social hierarchy within the household itself, with Jessamyne’s relationship with her *suegra* deepening when her mother-in-law learnt of her pregnancy.

Jessamyne's domestic situation reflects that of many young, married women in the Andes today whereby extended families in rural communities often continue to live together under one roof, with different family members sharing communal living space (Van Vleet, 2009; Bourque and Warren, 2010). As a newly married woman, it is normal for Jessamyne to live in the house of her in-laws. In so doing, Jessamyne is subject to the rules of the house as set out by her new family. The *suegra* (mother-in-law), in particular, has a marked influence over a newly married wife, living under her roof (Bourque and Warren, 2010; Van Vleet, 2002). This influence is reflected in Jessamyne's reluctance to invite Janeth and I inside the house when we arrived to visit her: Jessamyne is keenly aware that the house in which she lives does not belong to her. Anthropologists have noted the unequal power relationships existing between mothers and their daughters-in-law across the Andes. *Qhachunis* (Quechua: daughter-in-laws) are subordinated within the Andean household to their *swiras* (Quechua: mother-in-law) in Bolivia and elsewhere (Van Vleet, 2002; de la Cadena 1991, 1997; Harvey 1994, 1998; Weismantel 1988:174). However, in Jessamyne's case, once her mother-in-law discovered she was pregnant, somewhat to Jessamyne's surprise; she took her under her wing and began to advise her and offer her support throughout her pregnancy:

"She began to tell me what I should be eating, that I should...that I shouldn't overstretch myself, that I should be stable...in a stable emotional state. So this gave me a bit of security, because there aren't many of us who expect to hear things like that. Well, we expect them to criticize us, to say to us "You have to take precautions"¹⁰⁸, - you know? - "Because now your life is going to end". So, I, well, I became a bit more secure. The months went by...three, four months and my mother-in-law was always calling me you know? "Jessamyne, let's see what we are going to cook for ourselves today" or "Have some of this, you should eat lots of fruit"... a little bit like she was starting to spoil me, to see me as more important, to be affectionate towards me. And that gave me the absolute security to go ahead and just have my baby. And well, I'm carrying on, I'm eight and a half months pregnant now and I'm more and more excited all the time because even my husband's grandmother has been knitting for the baby..."

¹⁰⁸ Jessamyne's words were "*Tienes que cuidarte*" which literally means "You have to look after yourself". However, in Peru, amongst Andean families and the health professionals who cared for them, "*cuidarse*" meant to use family planning. Hence I have translated it as "take precautions (against pregnancy)".

Jessamyne's status within the household has changed: now pregnant, she is assigned more importance by her mother-in-law within the family structure. She is no longer the subordinate "new wife" but a future mother and directly responsible not only for her own change in status, but also for a change in status for her *suegra*. When the baby arrives, she will become an *abuela* (grandmother) for the first time. The family wide acceptance of her pregnancy, illustrated by Jessamyne's reference to the knitting her husband's grandmother is doing for the baby, serves to make her feel more secure and gives her the courage to continue with her pregnancy. Her mother-in-law's behaviour towards her has changed for the better: she is affectionate and caring towards her, whereas before Jessamyne and her mother-in-law did not enjoy such an intimate relationship. The moral and emotional support offered by her mother-in-law is thus extremely important to Jessamyne and is pivotal in convincing her to carry on with her pregnancy. She ends her narrative reconsidering her earlier thoughts regarding a possible abortion:

"Oh no, what was I thinking, you know? (I would have) made the worst mistake. Well, I mean, this type of (family) attitude makes you feel...well, stops you feeling alone. And well, the family support has helped me a lot."

The ethnographic contribution of Jessamyne's story lies principally in that she embodies the 'model' well disciplined patient for the Ministry of Health. She is a young, Andean *gestante*, whose narrative reveals that she is fully cognizant with her 'responsibilities' as a new mother-to-be as set out by the Ministry of Health. In contrast to Rosalinda, discussed in the previous chapter, Jessamyne has attended all of her antenatal appointments, welcomes health professionals during their Home Visit schedule, happily discusses her Delivery Plan with them and duly completes and signs all relevant documentation. She is fully aware of the danger signs to look out for in pregnancy, able to recite them to Janeth during her Home Visit, and has a plan in place to enable her to get to the clinic in the event of an obstetric emergency. In addition, her family wholeheartedly support her in her pregnancy: her husband encouraging her to continue with her pregnancy when she was unsure whether she wished to do so, and her mother-in-law offering advice, practical and emotional support throughout her pregnancy and guiding her in her choices about where and how to give birth.

Jessamyne's story supports the findings of Paola Sesia (1996), whose ethnographic study of authoritative knowledge and childbirth in Mexico highlights the active role that key family members – in particular a pregnant woman's husband, mother or mother-in-law – play in managing reproduction. She argues that pregnancy and childbirth are complex phenomena in which “social control mechanisms, cultural values and locally prevailing norms play important roles” (1996:135) and underlines the need for maternal health interventions to include family members as important participating social actors otherwise such interventions risk failure. In the following section I discuss how Peru's Ministry of Health has aimed to reflect the centrality of familial involvement in birth through press releases, documents and promotional imagery. In doing so I draw attention to familial understandings of what their involvement in childbirth should mean, and the potential conflict arising from institutional expectations communicated through closer analysis of the Delivery Plan.

Promoting familial involvement in *Parto Institucional*

Throughout my field research in both Chiara and Izcuchaca, Andean women, when sharing their memories about their birth experiences, repeatedly reiterated how important it was for them to have their family members around them when they gave birth. As I discussed in Chapter 3, the lack of familial proximity to her designated birth clinic prompted Elena to flee with her husband at night from the clinic in Huancaray to Andahuaylas to give birth in the hospital there, the town where her family lived, indicating an inflexibility in the Delivery Plan, which places more importance on women giving birth in particular health establishments, regardless of the proximity of the clinic to their family members. Similarly, Milagros's initial refusal to travel to Lima for emergency treatment after the birth of her son was underpinned by her fear of being separated from her newborn son, and hospitalized without her husband and family for support, again pinpointing a failure in policy planning which does not account for how family members are to be transported in emergency situations. Birth is thus very much considered a family event in the Andes (Portela and Santorelli, 2003), with not only the mother-to-be's husband present, but also other close family members such as her own mother or mother-in-law or elder children, all of whom are involved to a greater or lesser extent in the decisions taken as birth progresses. As I showed in Chapter 4, when Rosalinda arrived at the *Posta de*

Salud in Chiara to give birth, she did so with her husband and her mother-in-law accompanying her and both remained present throughout her labour offering her advice, moral and emotional support, providing her with hot drinks and physically supporting her as she gave birth. The following morning, there was a constant stream of family members and neighbours visiting, including all of her other eight children, however young, who all took turns to cradle their newborn sister. Similarly, Elena, recounting the birth of her youngest son, remembered the birth as a happy event in the hospital in Andahuaylas as her husband was with her along with her eldest daughter who watched her younger brother be born.

For Andean women then, familial involvement in pregnancy and birth involves shared decision making, and is very much regarded as an emotional and pragmatic support mechanism. For the Ministry of Health, familial involvement in pregnancy and birth is viewed as a means to encourage women to agree to a clinically managed birth. MINSA's training manual on vertical delivery¹⁰⁹ states:

“The Delivery Plan is an effective tool that seeks to organize and mobilize family and community resources for the timely assistance of the pregnant woman, the mother who has just given birth and the new-born. The plan must set forth specific information to allow organizing the assistance process for the pregnant woman, indicating the aspects of delivery and referral if necessary. The plan provides the necessary information so that the pregnant woman and her family know where to go upon evidence of imminent delivery or alarm signals”.

(MINSA, 2005:18)

Thus the Ministry of Health mobilises the Delivery Plan as a means to ensure that the families of Andean women like Jessamyne plan how they are going to get her to the clinic to give birth, reflecting the drive to promote *parto institucional* as a familial and community responsibility (as discussed in Chapter 4). The Plan itself (Figure 23) asks for a community telephone number, and details of who is going to bring the *gestante* to the clinic. Family members are required to sign the document in addition to the pregnant woman and the health professional, thus legally responsabilising them.

Further, in highlighting the danger signs to be aware of in pregnancy (Figure 23), the plan becomes – as stated above – more than “a tool” to ensure a clinically managed birth, it represents part of the infrastructure of healthcare provision in rural areas of the Andes. Ostensibly educational in nature, nevertheless by using emotive language in training manuals (“Imminent delivery”, “alarm signals”: see above) and on the Delivery Plan itself, where *senales de peligro* (danger signs) are capitalised along with instructions to go to hospital immediately (also capitalised), the Plan reinforces the message for both health professionals and their patients that clinically managed birth is necessarily the safest option ¹¹⁰

Additionally, MINSA press releases and promotional materials are also carefully constructed to promote familial involvement in *parto institucional* (Figure 24), whilst simultaneously championing intercultural health initiatives. For example, the photographs in Figure 24 depict images of Andean women giving birth in MINSA run clinics, accompanied by family members and health professionals. In both images, the women are giving birth in an upright position – *parto vertical* – the importance of which I discussed in my literature review. The composition of the photographs is important. In Figure 24, to the right of the pregnant woman and filling the frame, stands another older, indigenous woman¹¹¹ dressed in the typical clothing of her *comunidad campesina*. In her hands she holds what appears to be an open water bottle¹¹² and her gaze is directed down towards the obstetrician. The open bottle and direction of her gaze implies that she is actively engaged in the progress of the birth. In both images, the obstetrician is seated in the fore ground, dressed in full surgical gown, facemask and cap, attending to the pregnant woman. The faces of the obstetricians cannot be seen. The background to the pictures shows neatly arranged cabinets or ambiguous storage containers. On top of the filing cabinet in Figure 24, a

¹⁰⁹ Technical regulation for vertical delivery care with intercultural adaptation (N.T. No 033-MINSA/DGSP-V.O1) / Ministry of Health. General Directorate of People’s Health. National Sanitation Strategy for Sexual and Reproductive Health — Lima: MINSA, 2005

¹¹⁰ There is a significant literature which queries the supposition that home birth is necessarily more dangerous than clinically managed birth. See Ole Olsen (1997) for a meta-analysis of home birth in the Western world; Ole Oleson and David Jewell (1998) on home versus hospital birth; Debora Boucher et al. (2009) on women’s birthing preferences in America; Debra Jackson et al., (2003) on collaborative birth centre care versus physician lead care; Mary Regan and Katie McElroy (2013) on childbirth risk and place of birth; Goodburn and Campbell (2001) on the importance of sector wide approaches to reducing maternal mortality across the global south.

¹¹¹ The woman’s role is ambiguous: she could be a family member, either the pregnant woman’s mother or mother in law.

framed image of Christ depicted in the Catholic tradition of the Sacred Heart can be seen and just in shot in both images, there is a publicity poster promoting institutionalised childbirth.



Figure 24: *Parto Vertical* (Upright Birth). Source: MINSA, 2010.

The carefully composed images position the Andean family centre stage. Using such imagery, which aims to transmit an inclusive, participatory message, the Ministry of Health thus harnesses the family as a strategy to promote clinically managed birth. In so doing, the Ministry invokes representations of ‘culture’, carefully incorporating cultural elements from home births: familial participation; *parto vertical* and its use of a birthing rope or stool (Cassidy, 2008; Gabrysch et al., 2009; Zug, 2013); the use of a white cloth tied around the labouring women’s head. The carefully constructed photographs and imagery that make up these maternal health campaigns are based around a major cultural challenge: that many Andean women do not want to give birth in a clinic because such a practice is outside of their cultural norms. Further, the policy of clinically managed birth rests on the supposition that if cultural elements from home births – such as familial participation - are incorporated into institutionalised birth plans the ‘problem’ will be adequately solved. The assumption is thus made by MINSA, that in providing for childbirth experiences which respect the cultural norms of the Andean communities, such ‘problem populations’ (Hacking, 2006) will be encouraged to swap traditional home births for safe, modern obstetric

¹¹² The bottle is likely to have contained an infusion of herbs which are used to bathe the baby upon birth, although this is implicit, rather than explicit in the photo.

clinic based births. The accompanying reports by MINSA and PAHO, published on their respective websites in 2012¹¹³, support these assertions, describing the success of the policy after ‘cultural adaptations’ to birthing practices were introduced. Both MINSA and PAHO attributed the rise in institutionalised birth, the avoidance of maternal death and the fall in neonatal death rates and adolescent pregnancy to the new maternal health policy and its focus on Interculturality with PAHO awarding first prize to a Peruvian Health Initiative¹¹⁴ in the highland region of Huancavelica for demonstrating “*buenas practicas*” (good practice) as part of its Safe Motherhood campaign.

However, the health policies and promotional materials described above, with their central focus on family inclusion in pregnancy and participation in birth, nevertheless fail to consider how Andean women are left to manage their maternal health outcomes when familial support is lacking or altogether absent. In the subsequent section, Violeta tells us her story as she travelled alone to Cusco for an emergency caesarean. The difficulties she encountered along the way, and her experiences within the hospital illustrate the tensions emerging in the way in which familial support is (or is not) lent to the *gestante* and institutional expectations of *what* is expected from the family. The centrality of familial involvement in decision making processes in maternal healthcare is clearly apparent: Violeta’s story illuminates what happens (or does not happen) when family are absent, and exposes the vulnerability of individual women to instances of Obstetric Violence, with important consequences for her fertility.

Violeta’s story: Obstetric Violence and Invisible Bodies

Violeta: “Some of the sisters¹¹⁵ said ... “get up quickly”. Yes, all of the sisters said that to me as I was lying there cut open in the bed. Well, I couldn’t be left alone; I didn’t even have the strength to hold onto anything. So I was there, lying down, trying to turn myself from one side to the other. “Oh, *now* she’s getting up! What time are you thinking about getting out of bed?” That’s how

¹¹³ http://www.minsa.gob.pe/portada/prensa/notas_auxiliar.asp?nota=11419 Accessed 20th March 2015

¹¹⁴ Proyecto de Salud Materna Perinatal con Adecuacion Intercultural http://www.paho.org/per/index.php?option=com_content&view=article&id=1845%3Apremio-centro-salud-huancavelica-proyecto-materno-perinatal&catid=979%3Anoticias-2012&Itemid=900 Accessed 20th March 2015

¹¹⁵ I discuss Violeta’s use of the term “sister” (*hermana*) to refer to her fellow patients later in this chapter.

they (the nurses) talk to you. Some (women) were there with their children...(the nurses) consulted with their families, you know? They were ok, they were getting up, they were back on their feet; they could already get up. I was still lying there abandoned. That's how it was".

Violeta began to cry as she recounted her memories of her stay in the Antonio Lorena Hospital in Cusco to me. I was visiting Violeta in her mother's home, shortly after she had returned to Izcuchaca having been discharged from the hospital in Cusco. Violeta, an indigenous 26-year-old married woman, mother of four and a patient at the clinic in Izcuchaca, had been referred to Cusco for an emergency caesarean having arrived at the clinic in Izcuchaca showing signs of pre-eclampsia. Sara, Violeta's obstetrician at the clinic and I, on our way out of the clinic to buy bread rolls one lunch time for the staff, had spotted her waiting patiently in the doorway for an appointment. Sara pulled her from the queue asking her what she was doing there. Violeta said she had a headache and had come to ask for some tablets. Showing Sara her swollen hands, feet and ankles, she was immediately ushered through to Obstetrics.

Violeta remained in Obstetrics for several hours. The department is small, consisting of three consultation rooms each equipped with an obstetric bed and a "Doppler"; portable foetal monitoring equipment. Other than this, there is limited obstetric equipment. A delivery suite next door allows for natural delivery, but is not equipped to deal with caesarean sections, nor obstetric emergencies. There is a small ward, with four beds for new mothers to rest adjacent to the delivery suite, prior to giving birth or post delivery. Violeta was shown into one of the consultation rooms. Sara told her she would have to go to hospital in Cusco because her baby's health and her own life were in danger. Violeta sat on the bed and cried. She said she could not go because she had no one to look after her children in her absence. Her husband was living and working in Puerto Maldonado, some 20 hours drive away from Cusco. Her mother was unable to look after her children because she was not currently in Izcuchaca. As late afternoon turned into early evening and Sara finished her shift and prepared to go home, Violeta remained in the consultation room, sobbing and swinging her swollen feet back and forth. Janeth arrived to cover the night shift and reiterated to Violeta that she must travel to Cusco. Repeating that she had no one to care for her children, Janeth allowed Violeta to leave the clinic to go and cook supper for her children provided she phoned her mother to come and care for them that night. They agreed

that Violeta would return immediately that her mother arrived and spend the night in the Obstetrics ward at the clinic under observation. The following morning, the attending doctor, completing his morning rounds, immediately ordered Violeta to Cusco for an emergency caesarean, overruling Janeth's decision to place her under observation. Violeta was dispatched alone, by public transport with her referral papers and *historial* (medical history) in her hand. There was no ambulance available to transport her, nor a health professional or family member to accompany her on the hour-long journey.

A week later, when I went to visit Violeta at home, I found her pale, drawn and weak. Her premature baby daughter was tiny, sleeping in a crib just inside the door to the house. Violeta and I were sat outside on sawn logs, fashioned into benches, in the Andean sun. Her mother walked to and fro, hanging washing, completing chores and speaking to Violeta now and again in Quechua. Still sobbing, Violeta continued her story. She told me how she had felt alone and abandoned without her family around her, the nurses treating her badly, speaking harshly to her and disrespecting her. Without her family for support, she had had no one to bring her food and had gone hungry in the hospital. She told me how the nurses shouted at her, telling her to hurry up and get out of bed at six o'clock on a Wednesday morning, less than 24 hours after her surgery. Already discharged from the hospital, the nurses needed her to vacate the bed, to change the sheets. Violeta recounted how she slowly got out of bed, dressed herself in the hospital-issue robe and went in search of her new-born daughter, anxious to leave. One of the nurses chastises her:

Violeta: "Oh, and why haven't you taken your things with you? Why have you left them there?" I have to make the bed; I have to tidy it. That's how it is. So I say to her "I'm sorry Doctor" and I went on my way to find my daughter who I haven't yet collected. "And your bed? Is that it? Is that how you leave your house?" That's how she speaks to me. I haven't got the courage, because I am all cut open, and I'm alone...I'm not brave enough. So I say to her "I'm going to do it." I say it to her. Just like that."

Having made her bed, the nurse returns and tells Violeta to leave, to make her own way home:

“ ‘And now get out! What are you doing still here? Out!’ And....they threw me out. Yes. Some of the nurses were bad”.

As I have shown in the opening section of this chapter, Portela and Santarelli (2003) point out that familial input is crucial in developing a feasible plan to cover eventualities in case of obstetric emergencies (2003:65). Nevertheless, Violeta, finding herself at the centre of such an emergency, does not know how to react, other than sitting on the obstetric examination bed and crying, swinging her feet. Several hours were wasted – potentially critical to her life and that of her unborn baby – as she sat and cried, refusing to go to the hospital. Janeth, discussing Violeta’s case with me later, was convinced that Violeta’s apparent inaction was directly due to the absence of her family at that moment. Unable to call on her mother to care for her children, and with her husband some 20 hours away, she felt unable to take a decision on her own without referring to them. Decision-making in matters of maternal health is thus a distributed and shared responsibility between family members in the Andes. Institutional expectations however, call for immediate responses. Both Sara and Janeth repeatedly reiterated to Violeta that she must leave immediately for Cusco. I observed both obstetricians grow increasingly worried for Violeta’s health, and increasingly frustrated by her inaction. At times, their frustration over-spilled into anger. Now late into the night, with Violeta dispatched home to feed her children, Janeth leant forward in her chair, banged her fist on the desk in frustration, rolled her eyes skyward and shouted,

“I mean, Maria, what does she want me to do? Just sit here while she puts her life and her baby’s life at risk? There’s nothing I can do. *Nothing*”.

Violeta’s inaction and the tensions generated as it collides with institutional expectations supports findings in Kelsey Harrison’s work on obstetric care in Zaria, Nigeria (1983). She underlines the importance of family members – particularly husbands, mothers and mothers-in-law – as being active decision makers in the

management of reproduction (see also Sesia, 1996:135; Thaddeus and Maine, 1994). Harrison states:

“No matter how obvious the need for hospital management becomes for the girl ... permission to leave home for hospital can usually be given only by the husband; if he happens to be away from home, those present are often unwilling to accept such responsibility”. (Harrison, 1983:385, quoted in Thaddeus and Maine, 1994:1098).

Violeta, like the women referred to in Kelsey Harrison’s study, feels unable to make the decision to leave for the hospital on her own and only sets out there when she is ordered to by the attending doctor the next morning, who effectively absolves her of taking the decision over whether to seek Emergency Obstetric care (EmOC).

Violeta’s story thus illuminates the tensions emerging between familial and institutional expectations in situations where the urgent need for EmOC becomes apparent. EmOC aside, Violeta’s treatment once at the hospital also raises serious concerns over quality of care. As Violeta explained succinctly, “Some of the nurses were bad”. Violeta’s perceptions are reflected across anthropological research. During the last 25 years in particular, research evidence across Latin America shows that health services, particularly those operating in the field of reproductive health repeatedly fail to provide levels of adequate patient care. Roberto Castro (2014) goes as far as to classify reproductive healthcare in Latin America as being an area in which Obstetric Violence (OV) is exercised against women (2014:168). He cites international studies, which quote the testimonies of women who recount their reproductive health experiences with health professionals during labour; experiences, like Violeta’s, where many of these women were “mistreated, humiliated, intimidated or suffered abuses” (Asowa-Omorodion, 1997; Grossmann-Kendall *et al.*, 2001; cited in Castro, 2014.) Ethnographic studies in Mexico have also highlighted multiple cases of OV towards indigenous women (Pozzio, 2016; Gonzalez- Flores, 2015; Gamlin and Hawkes, 2015; Dixon, 2014; Belli, 2013; Sesia, 1996). Gonzalez-Flores (2015) points out the difficulties in defining ‘obstetric violence’ because its employment in reproductive health in Mexico is “subtle, pervasive, naturalised, normalised and institutionalised” (2015:4). Obstetric violence is defined as “Violence experienced by

women when giving birth (which is) promoted by healthcare officials” (Ibone Otza, 2013; Belli, 2013; cited in Gonzalez-Flores, 2015:3), with Ibone Otza quoting women who have suffered obstetric violence describing it as “birth rape” as they felt their bodies had been violated and coerced (2013:48). Quesada et al. (2011) posit that obstetric violence also constitutes structural violence because it is harm promoted by social structures and institutions; emanating from within health establishments and health linked development programmes (Leyva-Flores, et al. 2014; Pelcastre-Villafuerte et al., 2014) like *Oportunidades* in Mexico. Such programmes create structural violence as they disempower and harm women rather than support them (Paris-Pombo, 2008; Smith-Oka, 2012), reframing health promotion not as an issue about women’s bodies, but as a state controlled outlet to promote the interests of institutions such as population reduction (Paris-Pombo, 2008). Lydia Zacher Dixon (2015) argues that the obstetric violence experienced by indigenous women in Mexico mirrors deeper structural and symbolic violence perpetrated against women across Mexican society, precisely because, like Violeta, they are of lower socio-economic class or ethnicity (see also Belli, 2013). Illustrating her point, Zacher Dixon recounts how one indigenous Mexican woman who presented at the health clinic claiming to be unable to become pregnant, was found upon examination to have had an IUD device fitted without her consent or indeed her knowledge immediately after giving birth (Zacher Dixon, 2015:440).

There are echoes of what Zacher Dixon terms such “insidious incidences of violence” (2015:441) practiced on patients by practitioners in Violeta’s story. Health professionals in Cusco recommended that Violeta have a sterilisation immediately after her caesarean section was performed. Violeta agreed, explaining to me that not only her health but also the economic cost of raising her four children was an important deciding factor against having any subsequent children (see also de Zordo, 2012). However, during our home visit to Violeta in Izcuchaca, Sara, her obstetrician, could not find any reference amongst the paperwork given to Violeta on being discharged from hospital which indicated that a sterilization had been performed, despite Violeta’s assurances that she had been recommended one by health professionals and that she had given her consent that the procedure be carried out. Like the Mexican woman in Zacher Dixon’s ethnographic study, fitted with an IUD device without her knowledge, Violeta is now in a similar situation: unaware of the

status of her own fertility. The lack of adequate recording of surgical interventions; the possibility that the paperwork relating to her sterilization has been misfiled or lost; the possibility that Violeta's request was ignored and the sterilization not carried out at all; all point to the "mundane violence of the everyday" practiced in the delivery room (Rylko-Bauer et al., 2009:48) that indigenous women are subjected to. Violeta is now left in a precarious situation: neither she nor her obstetrician who cares for her gynaecological health know for certain if she has been sterilized or not. If the hospital in Cusco cannot confirm that the procedure has taken place, Violeta risks further pregnancy, increased health risks and of course further surgical intervention in order that the procedure be carried out.

Violeta's story exposes a relationship between familial involvement in maternal health and Obstetric Violence. Women are made more vulnerable to OV when they can be individualised and removed from a collective, familial grouping. Violeta herself recognises her vulnerability and seeks to protect herself from it, drawing the other women in the ward into conversations with her. The other women also recognise her potential exposure to OV: they draw her into a new 'family' collective, addressing each other as *hermana* (sister), and urging her to get out of bed before she incurs the wrath of the nurses.

Violeta's story can be read as unusual, given that wider familial involvement in pregnancy and birth dominate decision making processes (as discussed above). Nevertheless, Violeta finds herself alone in the clinic, without any of her family around her. Her story thus underlines the assumptions that underpin MINSA's maternal health policy, promotional materials and maternal care infrastructures such as the Delivery Plan. Firstly, the Ministry of Health assumes that a pregnant woman's family will necessarily be supportive. Secondly, the extended family's capacity to be present at birth is also assumed. Situations like Violeta's, where family are absent due to geographical distance, work commitments elsewhere or child care responsibilities are simply not accounted for. Neither does the Ministry take into consideration what happens to women who are referred on to another health establishment for EmOC like Violeta (and Milagros as I will discuss in the following section), when these hospitals are located at a distance from where they live. In such cases, women like Violeta are simply left to fend for themselves, leading to feelings of abandonment and loneliness as Violeta articulated.

Alice Street, in her ethnography of infrastructure and personhood in state hospitals in Papua New Guinea (2014), has drawn attention to such feelings of loneliness and abandonment experienced by patients interned in hospital and separated from family members through geographical distance. Street argues that in such cases patients begin to feel invisible – not only to family members – but like Violeta, to the health professionals and the state. In Street’s study, feeling fear and desperation, as her patients recognise that kin are unable (or indeed unwilling) to help them, her patients begin to monitor their relationships with guardians, relatives in town and hospital workers simultaneously searching their bodies for signs of minute improvement, much like Violeta, seeking comfort and solace in the support of the women on the ward. My research also highlighted further examples where women arrived at hospital alone to receive EmOC, having been separated from their families. As I discussed in Chapter 3, Milagros was forced to travel alone to Lima to receive EmOC after giving birth to her son. I return to her story below, to investigate how she assimilates her traumatic after-delivery experiences, without her family around her, and how like Violeta, her experience has unexpected consequences on her future fertility.

Milagros’s Story: Fear, embodiment and *post partum* illness

Milagros told me about the lonely days she spent in the hospital in Lima without her new-born son, after she was flown for emergency medical treatment by helicopter from the Hospital in Andahuaylas, as I discussed in Chapter 3. In a series of referrals and counter-referrals through the public health system, Milagros was sent by public transport on a two hour journey from the *Posta de Salud* in Chiara to the clinic in Huancaray to give birth. From there, she was referred on to the hospital in Andahuaylas, suffering from pre-eclampsia; a journey of another three hours. She had given birth there and overnight her blood pressure rose alarmingly. Once more, she was referred on, to a larger hospital in Lima. She was transferred alone, her son remaining behind with his father in the hospital in Andahuaylas. Milagros recounted how the news was broken to her and the doctor’s reactions when she agreed to go, although she did not want to:

Milagros: “He (her son) is just going to stay here with us, we will take care of him”. As I had already given birth my journey was covered, but my husband’s wasn’t. “Your husband isn’t going to go with you, you are going to go alone. Is that why you don’t want to go? You are going to go alone in the plane too”, said the Doctor. When I said, “ok, I am going to go”, then at that moment...yes, of course, he was all so *happy*. I don’t know why it is; the Doctor was really nice to me then. But when I didn’t want to go they were all bitter. I don’t know what they get out of this, I don’t know how it is.”

On arrival, Milagros was taken for the first time in her long journey by ambulance to the hospital. She expressed the fear she felt arriving alone in the hospital, describing how she was wheeled on a stretcher down a long corridor from the entrance to the treatment room. She described her feelings of disorientation: she did not know where she was being taken and even to where she had arrived. No one explained anything to her: where she was or what was about to happen to her. Milagros was left to look around her in alarm from the vantage point of a hospital gurney. She was taken upstairs to a treatment room, which increased her fear, as she was left next to another woman who appeared gravely ill.

“I was there looking around me. There were a lot of people. I was alone; there was no one from my family. I don’t have family there (in Lima). I was all alone. I was just there, looking around. My brother lives in Nazca¹¹⁶, they called my husband when I hadn’t yet been discharged. Then they told me my brother was coming. I was so happy to see my brother.... Oh, I was so happy. “Here’s my brother”, I said to myself. “Ask my brother”, I told the Doctor. “What? Is he family?” the Doctor said. “Yes, he’s here” I told him. My brother said: “Now, don’t be afraid, they are going to make you better here”. But I had to go alone. “Right here” he said, “we’ll see you right back here”, and he went back inside. They checked me over inside. They made me climb up (on an obstetric examination bed). That’s where they put me. Next to me...there was a woman...she was in a worse state, like she was dead. This made me afraid, so very afraid”.

Milagros went on to describe how she did not sleep for two nights while she was in the specialist unit. She was placed next to other patients, both male and female, who were “in a sorry state”. She continued to fear for her life until she was taken

¹¹⁶ Nazca is a town located some 3 hours drive from Lima along the Pan American Highway.

downstairs to the normal maternity ward where she spent the remainder of her time next to another woman who had given birth and like her, remained in hospital for some days, whilst all the other patients came and went, being discharged quickly. Milagros talked to the other woman, and they tried to comfort each other, to lessen the fear they both felt. After 15 days Milagros was discharged and returned to Andahuaylas by public bus, a journey of some 24 hours from Lima, weaving through traffic travelling dangerously fast down the Pan American highway and then threading its way up through treacherous highland earth roads. She collected her son from the hospital in Andahuaylas, where he had remained under the care of her mother-in-law, yet unable to be discharged without his mother's signature. She could not breast feed her baby; for two weeks his grandmother had had no other alternative but to buy him formula with which to feed him, and now Milagros's breast milk had run dry. The economic cost of the milk weighed heavily on the family's finances and Milagros's husband had borrowed 100 *soles*¹¹⁷ from his brother, which stretched only to cover their return bus fares and some food from Lima to Andahuaylas. Despite being told that their health insurance would cover their return journey, they received nothing. When they arrived in Andahuaylas, there was a transport strike and the newly reunited family were forced to spend a day and night sleeping on the floor of the draughty bus terminal waiting for the buses to resume service. Wrapped only in her brother's coat for warmth, Milagros felt afraid once again. She did not want to fall ill and she had no family living nearby that she could call upon for help. She decided that they should leave and walk to Huancaray. Her husband did not want her to, afraid for her health so soon after giving birth. Milagros was in a lot of pain: "My back hurt, my stomach hurt, I arrived there aching all over", but now reunited with her son, she turned her attention to him, and made herself get on her feet and begin to care for him. Persuading her husband they would be better off at home even if they had to walk there, the family arrived in Huancaray where they spent the last of their money hiring a taxi to take them back to Chiara. Milagros's chest and back were hurting her so much when she arrived home she went straight to the *Posta* where the staff gave her an injection for the pain. She was given another injection the following day and remained in the *Posta* for two months, weak and unable to walk. Milagros has never recovered her full health: since her son's birth, she told me that she has suffered from

¹¹⁷ In 2018, 100 soles is equivalent to approximately 20 GBP.

dizziness, nausea and severe headaches often feeling weak and unable to carry out her housework and caring for her livestock as she did before. Milagros now receives contraceptive injections from the *Posta de Salud* in Chiara, having decided she does not want any more children as a result of her traumatic experience.

The importance of having her family around her as she gives birth is threaded through Milagros's narrative. Milagros's story reflects how separation from family immediately after birth causes difficulties for new mothers on several levels. Firstly, there are the emotional consequences of the separation that the new mother must contend with: foremost in Milagros's narrative is the repetition of the fear that she felt travelling by helicopter – a mode of transport that she had never experienced before – and the fear of the unknown as she arrives at the hospital and is wheeled alone to the emergency ward. There are key similarities in Milagros and Violeta's narratives. Both feel keenly the absence of emotional support without family around them, coupled with the lack of privacy afforded them: Milagros as she is placed in a ward with both male and female patients (Thaddeus and Maine, 1994:1096), Violeta as she lies cut open in her hospital bed for all in the ward to see. Milagros, like Violeta, draws on the comfort offered by other patients as she is transferred to the maternity ward to stem her on-going fears.

Her story also builds on Violeta's narrative, as she describes the pragmatic and logistical difficulties (Thaddeus and Maine, 1994) encountered by her family as they struggle to visit her. Whilst her transport costs are covered by virtue of the SIS medical insurance, her husband must journey alone and at his own expense to Andahuaylas. Her mother in law must also stay in Andahuaylas at her own expense as she takes over the role of caring for Milagros's infant son during his mother's hospitalisation in Lima. The difficult logistical situation is relieved somewhat when her brother arrives in Lima and is able to loan the family money to cover their expenses. However, economic support aside, it is the physical presence of Milagros's brother at the hospital that serves to calm her fears and reassure her. In the absence of her husband, Milagros immediately authorises her brother to take over the decision making with regard to her care. When he arrives, Milagros instructs the Doctor "Ask my brother". In response, the Doctor asks if he is family and she responds, "Yes. He is here". In this way, Milagros hands over decision making about her maternal care to

her brother, who then instructs her about what will happen, reassuring her he will be there waiting for her.

If the importance of family proximity to Milagros threads through her story, the entanglements and complexities of the local context shape her maternal health experiences. Joao Biehl and Adriana Petryna (2013) have stressed the profound discrepancies in how health policies are envisaged to work and the concrete ways in which they are actually implemented or received by ‘target populations’ (2013;10). Milagros’s birth experiences shed light on the “entanglements between systems and human experiences” (Biehl and Petryna, 2013:13); her story is woven together in a series of disjointed health encounters as she is transferred from one health establishment to another. The way in which the state health system is organised and functions in Peru, requires that women like Milagros, who become ‘medical emergencies’, are transferred from one hospital to another, as local hospitals lack the necessary infrastructure and specialist staff to effectively treat the patient. Thus the participatory familial birth experience Andean women wish for and which is promoted by MINSA is cast aside as Milagros travels from Huancaray, to Andahuaylas and on to Lima alone. As Catherine Maternowska’s ethnographic study of patient care in a family planning clinic in impoverished Haiti (2006) and Nancy Scheper-Hughes’ ethnography of the ‘violence of everyday life in Brazil’ (1993) have observed, – grinding poverty, inadequate health infrastructures and resources, poor transport - all impinge negatively on women’s reproductive health experiences and outcomes.

However Milagros’s story, in foregrounding the social dimension of childbirth and *post partum* experiences, is not just the story of an Andean woman who finds herself alone and afraid in an unfamiliar hospital. Milagros’s story reveals important long-term consequences for her health and her future reproduction. In describing her debilitated state after giving birth to her son, her story also makes visible an Andean *post partum* condition known as *Sobrepardo* (Bradby and Murphy-Lawless, 2002; Larme and Leatherman, 2003; Loza and Alvarez, 2011; Kuberska, 2016), which can be translated as “too much childbirth” (my translation). Whilst *sobrepardo* has traditionally been analysed in terms of health and illness (Larme and Leatherman, 2003) following the ethnographic work of Kristina Kuberska (2016), I use *sobrepardo*

as a lens to view the wider, processes at work in Andean women's reproductive lives and their maternal health.

Ethnographers have classified *Sobrepardo* as an Andean condition occurring when women are unable to observe their traditional *post partum* practices such as staying warm, not touching water, avoiding exposure to cold air or winds or being unable to eat appropriate foods (Loza and Alvarez, 2011; Larme and Leatherman, 2003; Bradby and Murphy-Lawless, 2002). Symptoms include chills, sweats, headaches, dizziness and general weakness; leaving a new mother unable to care for her baby and, if untreated, suffering from chronic debility (Kuberska, 2016); symptoms which Milagros described herself as suffering from since giving birth to her son. Kuberska (2016) notes that *Sobrepardo* usually occurs in the post natal period, at a time when a woman would like to rely on members of her household or closest relatives but may be unable to do so, as was the case for Milagros.

In her ethnography of migrant women in Bolivia, Kuberska (2016) argues that migration, due to its reduced social network, increases the likelihood and incidence of *sobrepardo* as Andean women, relocating to Santa Cruz in Bolivia leave behind their family and kinship network. The loneliness this generates becomes embodied as *sobrepardo*. Following Kuberska's rationale, I argue that the manner in which Andean women, like Violeta and Milagros, who become reclassified as medical emergencies and are thus necessarily separated from their families and support networks during or immediately after childbirth as a result of the fractured and piecemeal nature of maternal healthcare provision, also induces *sobrepardo*. In framing her birth experiences around her subsequent symptoms of *sobrepardo*, Milagros shows us what, in her opinion, is important in her life. In so doing she allows us to see aspects of her life, which move beyond illness episodes to reveal how the complexities of the everyday interact. On an individual level her descriptions of *sobrepardo* point to understandings of the body: how she perceives her health after childbirth, her reproductive history and the centrality of support from family and kin networks to her everyday existence. On a wider scale, her descriptions of *sobrepardo* can be understood as social commentaries on the structural issues that affect women's maternal health: such as the political objectives underpinning health policy which promote clinically managed childbirth in the Andes in response to an increasingly globalised health agenda, where biomedicine dominates as a model of health and

illness (Tapias, 2015). Thus, the connections between individual experience and the wider structures within which Andean women's health choices and outcomes are embedded become visible. Binding these choices and outcomes together is the family: for Milagros, Violeta and Jessamyne the inclusion of their family members in making decisions and being actively involved in the processes regarding their maternal and reproductive health is paramount. When structural issues such as work commitments, childcare responsibilities, geographical distance or health system constraints conspire to prevent this, family absence is not only keenly felt, but also has significant impacts on Andean women's maternal and reproductive health.

Conclusion

This chapter has examined how family become bound up in maternal care as it is practiced in state run clinics across the Andes. The stories I have retold above have important implications for the way in which maternal health is delivered to, understood and received by Andean women. Whilst Jessamyne, Violeta and Milagros's experiences reveal different facets to familial involvement in pregnancy and birth, the importance of familial participation is a common thread running through and binding together their maternal experiences.

Recognising the importance of such familial participation, the Ministry of Health actively 'recruits' family members to promote *parto institucional*. Delivery Plans encourage pregnant women to agree to clinical birth in their nearest designated health establishment. Jessamyne's story shows that the Delivery Plan is most effective when discussed with family members (Portela and Santarelli, 2003) to obtain a feasible birth plan. As Jessamyne asserts, her *suegra* (mother-in-law) was instrumental in preparing her for delivery, offering advice and moral and emotional support (Lubbock and Stephenson, 2008; Sai and Measham, 1992). In close discussion with her *suegra*, and following the recommendations on the Delivery Plan, Jessamyne agreed to a clinically managed birth, regarding it as her safest option. The completion of her Delivery Plan, in which her family members are expected to countersign the maternal health choices written down, thus formally responsabilises them to act in getting her to her nearest health establishment to give birth.

Jessamyne's story highlights how familial involvement in pregnancy and birth come to mean different things for the different actors involved. For Jessamyne, and Andean women like her, familial involvement in pregnancy and birth is to be a shared, participatory experience, where decisions pertaining to birth choices are taken together (Portela and Santarelli, 2003), and family are expected to be present at the birth to offer emotional and pragmatic support. The Ministry of Health, however, mobilises the family as a 'technology' to ensure that pregnant women attend their nearest health establishment to give birth, regardless of the proximity of that health establishment to other family members.

The 'recruitment' of family members is also seen in the use of promotional materials such as press releases and visual imagery, and raises important questions as to how culture is harnessed to achieve particular aims; in this instance to convince a pregnant woman to choose *parto institucional* over home birth. Photographs of clinically managed birth released by the Ministry of Health mobilise cultural elements – delivery techniques such as *parto vertical* (vertical birth) and the inclusion of specific items of clothing, foods or drinks for example – to highlight 'cultural adaptations' to institutionalised birth. Family members are positioned prominently in photographs.

In portraying the family in this way, the Ministry of Health exposes the cultural assumptions that underpin maternal policy: firstly that extended family will be necessarily supportive and secondly that they are capable of being present at birth. Violeta's story shows that this is not always the case: logistical problems such as geographical distance, work and childcare responsibilities mean her family are unable to accompany her to the clinic for Emergency Obstetric Care. Her story also exposes continuing cultural challenges, which the Ministry of Health, despite its attention to 'Interculturality in Health' currently overlooks. Without her family around her, Violeta feels unable to make a decision regarding her maternal care (Thaddeus and Maine, 1994; Sesia, 1996) and delays her treatment. Her narrative also exposes cultural challenges in the way impoverished rural women are treated when they present alone at a clinic. Individualised, they become vulnerable to instances of Obstetric Violence: Violeta is humiliated and verbally abused by the nurses and the sterilisation she requests is not recorded. She leaves the clinic unsure of the status of her own fertility.

Logistical and cultural challenges also weave Milagros's story together. Like Violeta, she is referred on alone without her family for EmOC, again laying bare the individualistic nature of maternal health policy. Her family face logistic and economic obstacles in trying to reach her at the clinic: no provision is made for them by the Ministry of Health to allow them to do so. Important cultural practices such as the *post partum* rest period¹¹⁸, when Andean women traditionally rely on family and kin for support (Loza and Alvarez, 2011; Larme and Leatherman, 2003; Bradby and Murphy-Lawless, 2002) are denied to Milagros as she must travel back to Andahuaylas to collect her son. Gaps in the continuum of her care thus become visible, as wider structural issues – such as the distances new mothers are expected to travel to reach health facilities; the transport difficulties they must negotiate to get there; the economic expense incurred in doing so, compound to impact negatively on their maternal health experiences. In Milagros's case, this in turn has far reaching long-term consequences on her health perceptions and fertility. The traumatic experiences she encountered immediately after giving birth to her son become embodied as *sobrepardo*: Milagros declares that she is weak, suffers repeatedly from headaches and is unable to work her fields as she did before the birth of her son. She decides that she is not going to have any more children as a direct result of her experiences. Whilst MINSA's current maternal health policy promotes birth as a shared familial experience, Milagros's story lays bare the gaps in care that become visible in the *post partum* period. Portela and Santarelli (2003) stress the need for a continuum of care throughout pregnancy, birth and the post-natal period (2003:59). They underline that for care to be effective it must extend from the household – that is the woman's family – to include care received at the first level facility (such as a *Posta de Salud*) through to care provided at the referral facility. Milagros's story shows us that currently, as maternal health is practiced and received in the Andes, this is not so.

This chapter has shown the complex ways in which family is bound up with maternal healthcare, yet highlighted the ways in which the Ministry of Health mobilises family members to encourage Andean women to agree to giving birth in an institutionalised setting through the use of a Delivery Plan and press articles promoting familial involvement at delivery. In the next chapter, I turn to the institutional landscape of the

¹¹⁸ This is discussed more fully in Chapter 7

clinic itself. I show how geography and logistics impact upon maternal health provision, access and recruitment in rural areas, examining the ways in which the Ministry of Health seeks to render rural populations visible to the state apparatus and health professionals must vie for visibility and state recognition of their work.

Chapter Six: Landscapes of Failure: Geography, Logistics and State Legibility

Introduction

In the preceding chapters I have shown how rural Andean women struggle to reconcile the responsibilities of daily life with the demands of maternal health policy requiring them to give birth in state run clinics which are often located at considerable distance from their home and family. In this chapter I turn an ethnographic eye to the institutional landscape (Foucault, 1980) of the clinic, to show how logistics and geography also impact upon the work carried out by health professionals charged with rural women's maternal healthcare.

Drawing on participant observations and semi-structured interviews with obstetricians and doctors at the clinic in Izcuchaca, I begin by examining new strategies introduced by the Ministry of Health, which require health professionals take a multi-sectorial approach to maternal health and also actively seek out their patients 'in the field'. I will show how geography and logistics intertwine to shape how the Ministry of Health and its workers perceive the populations they care for, and the ways in which specific health strategies become implemented to render rural populations legible to the state. I then draw out the impacts of these policies for health professionals, highlighting the disciplinary consequences they face and how such strategies increase workplace tensions. This leads me to a discussion on differing contractual obligations between staff and the Ministry of Health working in rural areas, which bring into focus how geography and logistics also shape the ways in which newly qualified doctors in Chiara are recruited into the Ministry of Health. I end, showing how recruitment policies raise issues of value and recognition underscoring the work health professionals do and raise concerns over the failure of the state and health services to recognise relationships between themselves and their workers.

A new 'Multi-sectorial approach' to maternal health

As I have described in Chapter 1, the *Interculturality in Health* initiative impresses upon health practitioners the importance of recognising and respecting different

cultural practices and understandings relating to healthcare amongst indigenous populations living in Peru. Practitioners are expected to take into account their patients' cultural norms when attending their patients. The *Interculturality* initiative underpins the drive to reduce maternal mortality statistics in rural areas of the Andes. As I have shown in previous chapters, Andean women are expected to attend their nearest *Posta de Salud* (health post) for regular antenatal check ups and to agree to a clinically managed birth in specifically designated birthing clinics, many of which offer *parto vertical* (vertical birth) as a delivery option. Such initiatives therefore rest on the supposition that obstetric consultations between patient and practitioner will take place in a clinical setting.

However, rural women represent a continued challenge to the public health system precisely because they live on the periphery of healthcare provision: rugged physical geography, inadequate transportation infrastructures and their remote location exacerbate their access problems. Intercultural healthcare cannot easily be provided because the women cannot easily be reached. Ensuring that a pregnant woman arrives at a health establishment for antenatal care and delivery is thus a key concern for the Ministry of Health. As I have shown in Chapter 3, in 2009, when Milagros gave birth to her son Miguel, maternal health outcomes were firmly positioned as the responsibility of the patient, her family and her community, with accompanying promotional campaigns such as *Compromiso de Todos* (Everyone's Responsibility) designed to reinforce the message (Chapter 3, Figure 19).

The campaign targeted rural indigenous women in particular, precisely because they lived in isolated highland villages located at a distance from their nearest health facility. Family, community members and authority figures were therefore responsibilised to ensure the new mother-to-be arrived at the *Casa Materna* or clinic in a timely fashion in order to give birth. In addition, Delivery Plans completed by patient and practitioner at a pregnant woman's initial antenatal appointment are also utilised as technologies of engagement to encourage the pregnant woman to agree to a clinically managed delivery as Jessamyne's narrative highlighted in Chapter 5. Once again, the Delivery Plan places specific emphasis on the importance of physically transporting the *gestante* (pregnant woman) from her village to the clinic: the *gestante*

is required to provide details of who will bring her to the clinic to give birth and how they intend to get her there (Chapter 5: Figure 25).

In recognition of the ongoing geographic and logistical challenges posed in transporting rural women to health establishments, in 2012, the Ministry of Health demanded that service providers take a new ‘multi-sectorial’ approach to maternal health (del Carpio Ancaya, 2013: Chapter 1). The rationale underpinning this new approach is that pregnant women living in rural areas rarely visit their referral clinic or hospital precisely because they live in isolated, rural communities, where their only access to healthcare is the *Posta de Salud* or health outpost. As in Chiara, the *Posta* is basic, often equipped with rudimentary resources and understaffed. Specialist practitioners visit rarely. As the nearest specialist clinic or hospital is several hours’ drive by infrequent public transport from their village, women are likely to visit once; they are not going to want to repeat the journey on another occasion for another treatment. Accordingly, under the new multi-sectorial approach, a pregnant woman attending a MINSA run health establishment will have access to a variety of specialists and receive a range of medications and advice during her visit to the clinic. A checklist, given to women at their initial antenatal consultation, details the various consultations they will have during pregnancy: dental, psychological, nutritional and child health, in addition to a blood test and antenatal scans. The checklist also reminds women to take Iron Sulphate supplements, familiarise themselves with danger signs in pregnancy and ensure their health insurance affiliation is up to date (Figure 25). Janeth, the obstetrician with whom I worked most closely in Anta, explains:

“Due to the high incidence of maternal and neonatal deaths, other strategies have been introduced...strategies which are working. But for us as obstetricians (these strategies) demand a lot of us ... much more. (We have to) meet certain prerequisites in antenatal attention so that our patient, our pregnant woman is redirected: that she has her analysis, that she has her antenatal scan, that she passes through Orthodontics, that Psychiatry see her, that Nursing see her, that she receives her food allowance, that the doctor sees her...so there are so many things that they ask of us. It’s all part of the package, all included... in order to see her closer up, to identify any alarm signals, whether it’s domestic violence, whether it’s in orthodontics, because it has been determined that if a woman has a lot of tooth decay this can lead to a premature birth. So how do I prevent a premature birth and in turn a neonatal death? I fix her teeth. So there are more cases, there is more work that they ask from us from this perspective.”

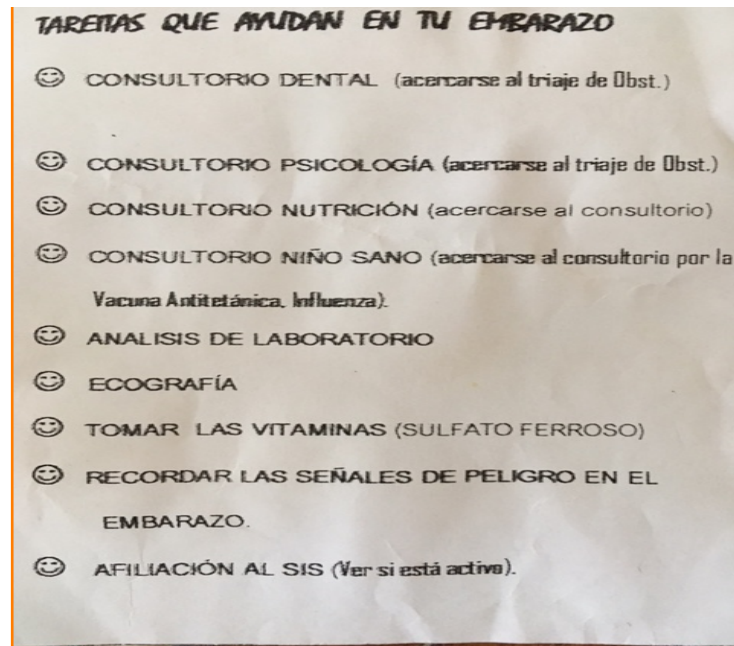


Figure 25: A checklist detailing the full range of entitlements and consultations for pregnant women available in MINSA run clinics. The list is given to every pregnant woman at her first antenatal appointment in Izcuchaca. My translation is below.

Tasks (sic) that help during your pregnancy

- Dental Consultation (see triage nurse in Obstetrics for referral)
- Psychological Consultation (see triage nurse in Obstetrics for referral)
- Nutritional Consultation (ask in reception)
- Healthy Child Consultation (ask in reception about tetanus and influenza vaccines)
- Laboratory Analysis
- Antenatal Scan
- Take Vitamin Supplements (Iron Sulphate)
- Remember the danger signs during pregnancy

As Janeth's words illustrate, this new multi-sectorial approach has brought increased workload and pressures to bear for the health professional in Izcuchaca. When a pregnant woman does visit the clinic, the attending obstetrician must coordinate her patient's visits to these other medical departments: completing the relevant paperwork for the referral through the various departments; ensuring the appointments are made; explaining the necessity of these appointments to her patient. Often, these other departments are not necessarily housed in the same building as the Obstetrics department: for example in Anta, there were no facilities to carry out an ultrasound. Antenatal scans required a referral to the Antonio Lorena Hospital in Cusco. If a patient preferred to have her antenatal scan completed in Izcuchaca, she would have to pay to do so at a private clinic, a cost which was often beyond her economic means in an impoverished area. Alternatively she could visit one of the many private businesses set up in Cusco, which offer a walk in service to the local population and where antenatal scans can be performed almost immediately, provided the patient can pay for the service. In Chiara, such referrals to different medical departments were yet more complicated given the very basic facilities available at the *Posta*. Visiting dentists ran surgeries once every few months, and such visits may be cancelled at the last moment if the earth roads were judged impassable due to heavy rainfall, or if there was no transport available to bring the dentist to the community. Antenatal scans had to be carried out in Andahuaylas, at the regional hospital. There was no regular attending psychiatrist available for Chiara and any analysis of bloods, urine or cervical smears and STI tests had to be sent via public transport to the clinic in Huancaray. I was often asked by *Posta* staff to deliver envelopes containing samples and the accompanying paperwork at the clinic in Huancaray if I was travelling past the clinic on public transport into Andahuaylas. If myself, or the staff at the *Posta* were not travelling into Andahuaylas on their day off, any urgent samples would be passed through the mini bus window to the driver who would be asked to drop them at the clinic door.

If the medical staff had difficulties in ensuring that samples and paperwork reached the clinic, it was even more difficult to ensure that patients attended their appointments. Women who lived in remote Andean villages often travelled for more than an hour on infrequent public transport to reach the clinic in Anta. From Chiara,

the clinic in Huancaray was a two and a half hour drive away on a crowded minibus, which left twice a day; the hospital in Andahuaylas a five hour journey. In Chiara, I heard conversations between health professionals and their patients many times, in which the doctor or obstetrician would explain the necessity of travelling to the clinic for follow up treatment and the patient would refuse to travel citing distance, expense and impracticality as reasons why they could not. Even if the patient were to travel that day, delays in receiving treatment at the referral clinic or hospital may mean an overnight stay in town and added expense.¹¹⁹ Hence, I witnessed tense situations develop between patient and practitioner on many occasions as both stood their ground and defended their stance: the practitioner constrained by the spatial organisation of the system which requires referral to other departments located in different geographical areas; the patient constrained by the responsibilities to family, home and a rural lifestyle in a largely agricultural community, as I have shown in Chapter 4. Thus tense situations develop with potentially dangerous consequences for the pregnant women and their babies the health professionals are trying to care for: as I have documented in Chapter 4, we see a heavily pregnant Elena running away from Doctor Juan Carlos refusing to follow his advice and stay in Huancaray to give birth, preferring to give birth in Andahuaylas with her family around her; Milagros alone and frightened in an unknown hospital in Lima referred on as a medical emergency after giving birth, her husband taken to the Police for questioning whether his wife should travel when so gravely ill (Chapter 3); Rosalinda repeatedly refusing to travel to Huancaray to give birth or even to attend the *Posta* at all for an antenatal check (Chapter 4).

¹¹⁹ I experienced such problems personally in 2010. After a road traffic accident, in which the local mini bus connecting Chiara to Andahuaylas skidded off the road and overturned several times, myself and other passengers who were injured in the accident were taken to the clinic in Huancaray by taxi. After some several hours in which I lay in a hospital bed with a suspected fractured spine we were all told we would have to go to the hospital in Andahuaylas for X-Rays. Several injured passengers refused to travel and discharged themselves from the clinic and made their way back to Chiara. That evening, myself and another injured woman were transferred to the hospital in Andahuaylas. We had to travel in another crowded public transport minibus as there was no ambulance available. On arrival at the hospital there was no one available to do our X-Rays and neither were there any beds available in the hospital. The other injured passenger discharged herself and went to stay with family in Andahuaylas. I had to walk to a hotel and spend the night there. The next morning, we were both asked to walk to a private clinic for X-Rays, the cost of which would be covered on the transport company's SOAT, or transport insurance. The other injured passengers arrived on public transport from Chiara later that morning.

The examples I have cited echo the logistical difficulties posed for impoverished, rural patients across the world when they are required to travel elsewhere for treatment. Paul Farmer and Joia S. Mukherjee (2012), in their work with Partners in Health in rural Haiti, have succinctly documented such difficulties, drawing attention to what Farmer terms “structural violence”: the structural impediments to healthcare access such as grinding poverty, unemployment, lack of adequate transport infrastructures, and tense political situations which prevent patients from accessing healthcare on a daily basis. Ministry of Health campaigns like *Compromiso de Todos* (Everyone’s Responsibility) and multi-sectorial approaches to maternal health attempt to alleviate some of these access difficulties for rural women, yet they increase health professionals’ workload as they come under pressure to coordinate across departments as I have shown. Further, the multi sectorial approach has important disciplinary consequences for health staff when they fail to provide their patients with the full range of entitlements, as I will discuss in the following section.

Disciplinary Consequences for Health Practitioners

On many occasions in Izcuchaca, I witnessed flurries of activity as a pregnant woman arrived from a remote community and was ushered through the system as quickly as possible: passed from one department to another. Staff understood that it was important that as many specialists see her as possible, as it was unlikely that she would repeat her long journey again so soon for another appointment at the clinic. If the woman was not seen that day, there was a high possibility that she would not be seen again during her pregnancy until she came to the clinic to give birth. Observing an antenatal session in Anta one afternoon, I saw Maribel, the attending obstetrician, personally escort a pregnant woman around the clinic to as many departments as possible, ensuring she was seen immediately. In each department Maribel explained to the doctor or clinician that the woman was from a distant village and must be seen immediately: Maribel later told me that she was sure that if the woman left the clinic without having seen all relevant staff, she would not return at a later date. The staff would have lost their opportunity to provide her with the healthcare package she was entitled to under the SIS, or health insurance scheme. In addition, Maribel explained, and as I have documented in Chapter 3, DIRESA, the regional health authority,

closely monitors the work of their personnel. Thus, the failure to complete the checklist of interventions (Figure 25) and provide the full range of health services to the patient would be observed and noted by MINSA when staff submitted their end of month statistics. A failure to meet consultation targets is likely to trigger an inspection visit from DIRESA to the clinic, and further increase pressure on staff to improve their statistics (Chapter 3). The pressures and intricacies generated by the new multi sectorial approach to maternal health for staff is amply illustrated in the consultation described below, which I observed as it happened between Janeth and a heavily pregnant patient in 2016.

In 2016, Janeth had relocated from Izcuchaca to Belén Pampa, the maternal health hospital in Cusco specialising in *parto vertical* (vertical birth) where she had accepted a promotion to Lead Obstetrician. I was visiting Peru to do some follow up fieldwork and called her to try to catch up with her. She asked me to meet her at the clinic. When I arrived Janeth was waiting for a patient from a village outside of the clinic's catchment area. She explained that Rocio, the 33 year-old woman, lived in Saylla, a village some 50 minutes drive from Cusco. However, because she worked in Cusco, Rocio wanted to attend her antenatal appointments at Belén Pampa. At 39 weeks pregnant, this was to be Rocio's first antenatal appointment. Whilst she waited, Janeth complained to me that the woman would cause her problems at the end of the month when she submitted her report:

“It will be noted by DIRESA that we didn't provide her with the complete package available to her. They will ask questions: why did you not get this patient on the books earlier? Why has she missed appointments? Why didn't you visit her at home? That's what they will say. But how on earth are we supposed to visit them at home when she doesn't even live in this area? There are only two obstetricians on duty at a time. Am I supposed to leave my other patients waiting whilst I go and visit her fifty minutes drive away? How am I supposed to do that?”

Rocio duly arrived at the clinic and Janeth began the consultation. Smiling wryly at Rocio she asked her why she wanted to have her antenatal appointment at Belén Pampa. Rocio smiled back and said because she worked in Cusco. Janeth exclaimed, laughing:

“Oh but *Señora* (Madam), you are making so much work for me! You are making life difficult for me! Why can’t you just go to Saylla! OK, well we will just have to fill in all the paperwork as best we can and I will try to refer you through the departments for your checks, but you know you are likely to give birth even before you have had half of them”.

The majority of the consultation was then taken up with Janeth reading out the danger signs that Rocio must look out for in pregnancy and ticking the corresponding box on the checklist as proof that the patient had been informed¹²⁰ Arriving at the danger sign “pain in the uterus’ Janeth paused, laughed, and said that in Rocio’s case that would mean the onset of labour given that she only had a week to go before she was due to give birth. Janeth then asked Rocio where she was intending to give birth. When Rocio replied in the *Posta de Salud* in San Jerónimo, a neighbouring town 30 minutes from Cusco, both Janeth and I exclaimed together:

“But *Señora*, you can’t give birth in the *Posta* anymore! They won’t attend in the *Posta*!”

Rocio insisted that they did. Janeth then turned to me and shaking her head said:

“What am I supposed to do? She lives in Saylla but wants to come to Cusco for her antenatal check – the first of which is today at 39 weeks! Then she wants to give birth in San Jerónimo. What are we supposed to do? How are we supposed to control all of this?”

At the end of the consultation, once Rocio had left, Janeth turned to Richard, the student obstetrician who was also in the room and who was helping her complete the large amount of paperwork this initial consultation generated. Janeth said to him:

“Make sure all this is noted down. I don’t want problems. Note down that the patient came for the first time today and she isn’t even from our area. Note down that she lives in Saylla but wants to give birth in San Jerónimo and we advised her that she couldn’t. Also note down the address where she works in case her labour starts when she is at work and she comes here. Note down all the referrals we have given her, but say that it is unlikely she will get them because she is 39 weeks pregnant. But, (*sighing*) we tried”.

The consultation lays bare the steps that health professionals must take in order to defend their work against criticism and possible sanctions from DIRESA. Janeth knows that she will be criticised for failing to carry out a home visit to the patient,

¹²⁰ See Appendix 1 for a copy of the forms and checklists that MINSA obstetricians must complete at every antenatal consultation.

despite the fact that the patient does not live in her catchment area. Distance makes it impossible for her to carry out a home visit: to do so would mean leaving other patients at the clinic unattended for most of the day. She is meticulous in instructing her trainee obstetrician to note fully the circumstances of Rocio's case: failure to do so opens her to investigation, sanctions and possible dismissal.

Disciplinary action aside, Janeth's consultation with Rocio sheds light on another important facet to maternal health provision which causes difficulties for health professionals charged with rural women's care. Women like Rocio - or Elena as I have shown in Chapter 4 – may prefer to give birth in clinics that are not necessarily the closest to their home. These women may not therefore attend all of the requisite antenatal appointments. However, because they do not belong in the catchment area of the clinic, these women remain unknown to the community health agents who monitor the local area and inform the health professionals of any new pregnancies (Chapter 3). Thus, obstetricians remain unaware of their need for maternal care until they walk into the clinic. These women are thus invisible to health professionals because they are able to evade the monitoring and governance strategies in place to ensure their regular attendance at a clinic.

Health professionals have therefore been forced to reassess how they succeed in providing healthcare to isolated populations. One of the ways in which practitioners working in Izcuchaca have attempted to attract new patients is through an 'outreach' strategy which I learnt about in 2012 when attending a meeting for staff working at the clinic in Izcuchaca and its outlying community *Postas* (health outposts), details of which I present below.

Reaching Out: Delivering Healthcare 'in the field'

When Janeth and I arrived at the upstairs meeting room in the clinic the room was already crowded with staff from different departments. I recognised several staff members from orthodontics, several of the doctors and nurses, the clinical psychologist and the obstetricians. Enrique, in his capacity as General Manager at the clinic in Anta, was about to address the assembled crowd. He explained that the focus

of the day's meeting was to explain a new 'outreach' strategy to be introduced in Izcuchaca. Several staff groaned and Janeth whispered to me "oh, yet more new strategies!" Enrique smiled good-naturedly, nodded in acknowledgement, and said, "Yes, I know, I know, but please let me continue". The outreach strategy to be introduced in the coming months focused particularly on attracting new patients to the clinic in an attempt to improve the attendance statistics. Enrique explained that DIRESA had noted that there was currently only some 33% of the population eligible to receive free treatment in the clinic actually registered there. The clinic would therefore be required to periodically run campaigns to *captar* or 'capture' new patients. Such campaigns were to involve staff from the clinic targeting a particular residential area in Izcuchaca, or travelling to a particular *comunidad campesina* in the clinic's catchment area, knocking on doors and encouraging people to register for treatment at the clinic, by filling in the relevant paperwork then and there (Figure 26). An integral part of the strategy, Enrique underlined, was that all staff – doctors included – were to go out into the wider community around Izcuchaca, not only to register new patients, but also to treat patients 'in the field' if necessary.



Figure 26: Outreach Strategy: Janeth carrying out a home visit to register new patients in a rural area. Photo: courtesy of Janeth.

The news generated mixed reactions from staff: some nodded in agreement and others were outraged. Doctor Jorge, one of the senior doctors, got to his feet and began to shout Enrique down. Waving his arms around and shouting angrily he made it clear that he would refuse to go out into the community, because as a *nombrado*¹²¹, he was employed to attend to patients in the clinic, not “*en la choza*” (in a hut)¹²², and as such his working hours finished at 2pm. Other staff joined in the affray, some supporting him and others objecting to his viewpoint, expressing the opinion that it was important to reach out to the community. For example, Doctor Grover, a physician working in private practice but who had previously worked in Izcuchaca, felt it was “imperative” that staff should spend time attending to their patients out in the field. Discussing the events of the meeting with me afterwards, he criticized the attitude of doctors like Doctor Jorge, who stood up to object to having to travel to remote villages and hamlets to attend to patients:

“What that doctor does not want to do is part of public health: prevention, promotion, treatment and recovery. They are the four pillars of public health. It has always been that way, and it will always be that way”.

In contrast, Dr. Anibal, a physician now working in private practice in Cusco, but who also worked for MINSA in the Andean villages of Sicuani and Pucallpa, explained the difficulties of attending to patients ‘in the field’ thus:

“They are inhospitable areas. They live in areas unreachable by health personnel and that’s it. You can’t get there by motorbike, or car. Sometimes you can only get there by horse and at times there are only bridle paths and it’s dangerous for the health staff as well. The people don’t live in a...well in a neighbourhood, you know? One lives in a little house and then some two or three kilometres away there is another little house...that’s how they live. So, it’s a rather large terrain to cover and so it’s very difficult to... for us to reach it”.

¹²¹ A *nombrado* is a member of staff on a permanent contract. I discuss the significance of this in subsequent sections of this chapter.

¹²² The *choza* is a shepherd’s hut usually made of mud brick and straw located in rural areas. They are regularly used as shelter from the elements by rural populations when herding their livestock in remote areas. (Note in Chapter 3 that Isabela told me she had given birth to her son in her *choza*).

Janeth agreed with the outreach strategy, explaining to me that for her it was important to travel to remote populations and try to actively attract patients to the clinic because:

“People don’t like to waste their time when they come here. They complain a lot about how we treat them; (they say) there are Doctors who don’t have any patience, who don’t want to attend (to them). The people upstairs registering you¹²³ don’t have any patience either... so what will they think, you know? “I’m going to die at home, I prefer that to being here”, they also say that. Well, the thing is they have other options, they can go to the pharmacies, they can go to the (private) clinic, or at the end of the day they can go to Cusco and they will attend to them. Here they see us as the last option. We also have cases like that”.

Following Doctor Jorge’s outburst at the meeting, the meeting began to dissolve into a series of verbal arguments and abuse amongst staff. The atmosphere was becoming unpleasant and Enrique called upon Fernando, the clinic’s psychologist to intervene. Fernando then began a series of activities with the staff at the meeting to unpick their reactions and try to understand better the reasons behind their discontent and anger towards each other. Writing on sheets of cardboard, the staff were encouraged to note down their feelings in single words and lay them out on the floor. The floor was soon covered with words like “powerlessness”, “frustration”, “anger”, “tiredness”, “overworked”, and “depression”. As staff began to explain the reasons behind such negative emotions, the poor working conditions, the differences in contractual obligations and the repeated changes to health strategy were prominent in the explanations put forward. The meeting was a long and difficult one, but it ended amicably with the majority of staff shaking hands with each other. A raffle to win a hamper of food and drink to celebrate the upcoming feast of All Souls on 1st November ensured that the meeting ended on a positive note.

The events at the meeting I witnessed bring to the fore important concerns about how public health interventions are provided to rural populations in the Andes. Geography and logistics clearly underpin initiatives such as MINSA’s new multi-sectorial approach and outreach strategy: by virtue of their remote location, rural women are designated as problematic. For MINSA, because access difficulties render these

women's visits to the clinic infrequent, when they do visit, they must receive as many specialist health interventions as possible. Some women do not come to the clinic at all, whether due to location and logistics or more pragmatic concerns such as domestic arrangements and familial responsibilities, agricultural work which limits their availability and mobility, or cultural and institutional challenges as I have shown in previous chapters. These women remain invisible to the Ministry of Health, unregistered and thus unable to access the maternal healthcare available to them. These 'problem populations' (Taylor, 2007) therefore become chosen to receive targetted interventions.

The ethnographic work carried out by anthropologist Alice Street (2016) in Papua New Guinea, has highlighted how such targeted inventions can in themselves be problematic. Street has documented how failures to access services have come to be interpreted as failures inherent in specific populations. Global health literature, she notes, regularly employs quasi-scientific terminology to describe population groups as 'high risk', 'hidden populations', 'marginalised populations', 'socially disadvantaged' or simply 'hard to reach'. She argues that certain segments of society are assumed to be at a high risk of mortality or morbidity due to their failure to receive or respond to public health messages. Often, definitions of 'hard to reach' populations are based on socio-economic status, ethnicity, lack of literacy or assumed cultural homogeneity (Street, 2016), markers which are regularly employed by the Ministry of Health in Peru, as I have illustrated in Chapter 1 (Figure 7). Thus, 'hard to reach' is harnessed as a convenient label to express the idea that particular populations are problematic. Consequently, 'hard to reach' becomes modified to describe a trait inherent in the population rather than a description of the difficulty service providers have in reaching them. When a spatial dimension is added, by virtue of geographical remoteness, hard to reach populations are transformed into hard to reach areas. Hence, Street argues, semiotic network terms such as 'universal coverage', 'access issues', and 'scaling up' of public health interventions are employed to describe public health interventions carried out by organisations, the state and the Ministry of Health working in the area. Thus, the challenge subtly shifts from being how to persuade

¹²³ In order to receive treatment at the MINSA clinic in Anta, patients must first register for the SIS (health insurance), which permits them free treatment. Registration took place in the offices located on the first floor of the clinic.

populations to access public health services, but rather, because there are places that remain inaccessible to state institutions, how to effectively bring the system to them. Consequently, the responsibility shifts back to the service providers rather than the population itself.

Hence, as Enrique made clear at the multi-sectorial meeting to introduce the new outreach strategy, health professionals would now be expected to travel to specific communities on particular days to register patients with the clinic. In this way, as Street (2016) has illustrated, the responsibility shifts back to the health provider to ‘bring the system’ to the patient. Certainly, in the weeks following the meeting, the staff notice board at the clinic would regularly have details of upcoming trips to outlying communities written on it. Included in the information would be the community to be visited; the targeted number of registrations to be achieved; the list of staff travelling and what their specific role would be; departure times from the clinic and expected arrival time back at the clinic.

The outreach strategy thus raises important questions about not only how specific populations are made visible to the state, but, in responsabilising its workers to actively register new patients, how the state apparatus employs its workers to render such populations visible. Anthropologists and other social scientists have closely documented the Foucauldian practices by which subjects are surveilled, monitored and disciplined (Waldby, 2003; Caplan and Torpey, 2001; Lyon, 2001; Scott, 1998). For example, Jane Caplan and John Torpey (2001) track the nineteenth century development of documentary practices through which every citizen was made visible through the issuing of passes, censuses and the like (2001:8). Birth certificates, medical records and passports, the authors suggest, are employed as “systematic regimes of registration” (2001:8). James Scott (1998) has also noted early attempts at state legibility in which citizens were centrally recorded and monitored, through projects as diverse as the design of cities, the establishment of cadastral surveys and population registers, in order to render them “more legible – and hence more manipulable – from above and from the centre” (Scott, 1998:2).

Population surveys carried out in Peru, under the auspices of INEI: *Instituto Nacional de Estadística e Informática*, (National Institute of Statistics and Informatics) classify

populations according to ethnicity, economic and social class, educational level, age and gender. The Ministry of Health uses INEI markers to compile health related statistics, as the graph in Chapter 1, pertaining to statistical differences in maternal mortality across populations, shows. With this statistical information to hand, the state is therefore aware that only 33% of the population in Izcuchaca, eligible to enrol for state funded healthcare, has actually done so. The majority of the population in Izcuchaca and its designated catchment area thus remain outside of state purview in terms of healthcare. Hence, women like Rocio who choose not to enrol at the clinic in their designated catchment area are able to evade the strategies in place to monitor reproductive health, ensure timely antenatal care and a clinically managed birth in their designated clinic as I showed earlier in this chapter.

In successfully evading the controlling nature of bureaucratic registration processes, these women thus bring into question the ability of the state to be ‘all seeing’. Recent anthropological studies have also questioned the ability of the state to adequately see its subjects (Street, 2012; Casper and Moore, 2009; Scott, 1998), thus challenging dominant Foucauldian interpretations of power-vision and governance emanating from a homogenous state apparatus (see Kierans, 2015; Mosse & Lewis 2005; Li 2005; Ferguson & Gupta 2002; Rankin 2001). Foucauldian discourse encourages subjects to turn a critical eye towards their own behaviours and adapt their behaviours to the established norms (Foucault, 1977).¹²⁴ However, as anthropologists have pointed out, not all bodies are surveilled and monitored in equal measure: Scott has noted how modern statecraft is selective in its representations of society, choosing to represent “only that slice of it that interested the official observer” (Scott, 1998:3). Indeed, feminist science studies scholar Donna Haraway, underlines the “selective blindness” (1997:202, cited in Casper and Moore, 2009) inherent within the politics of reproduction in particular, and across the ethnographic literature, instances of “stratified reproduction” whereby particular populations are encouraged to reproduce and others are surveilled and monitored to limit their reproduction, are well documented (Ginsburg and Rapp, 1995; Colen, 2009; McCormack, 2005; 2016).

¹²⁴ Chapter 4 discusses how Rosalinda was surveilled and monitored by members of her own village and repeatedly encouraged to modify her behaviour by fellow *chiarinos*, health professionals and state authority figures.

Medical anthropologist Ciara Kierans, in her work on transplantation practices in Mexico (2015) challenges the work of Scott, arguing that in non-Anglo American settings an already definable apparatus of state control, which structures visible constituencies or populations may be absent or inadequate. Kierans draws attention to the uninsured poor, who must navigate their way through Mexico's "intensely fractured and informal routes to healthcare" (2015:10) in search of kidney transplants and dialysis. She argues that because they are uninsured, the poor are not entirely visible to the state, remaining outside of state 'counting systems' and the formal public health system. By following their treatment trajectories and the work they must do to obtain healthcare, these patients make visible how the state lets them down as they are caught at the intersections of market forces and healthcare provision. Kierans' work underlines the importance of attending to definitions of biopolitics and the state in relation to the local contexts, practices and sites where they are made relevant.

After Kierans, I argue that the outreach strategy harnessed by service providers is another example of biopolitics at work in local context. Not only does it shed light on how specific populations – by virtue of their remote geographic location - become the subjects of targeted interventions, but it shows how health workers, in the absence of adequate health registration systems in Peru, are responsabilised to render previously hidden populations visible to the state by actively searching them out and registering them outside of the confines of the clinic. Thus there is a stepping up of activity on behalf of the state apparatus, as conventional forms of registration prove inadequate for purpose. Instead we see increased mechanisms of visibility through the disciplining of subjects and initiatives that ensure state level actors embark on geographically specific practices to bring previously hidden populations into state view.

As I have commented above, responsabilising staff members to travel to outlying communities and register new patients generated markedly different reactions when Enrique presented it in the meeting. I noted that doctors in particular were very divided on the issue. Doctor Jorge's comment that as a '*nombrado*' (a permanently contracted employee) he felt that it was not his responsibility to attend to patients in their local community lead me to investigate further what he meant by this. I uncovered marked differences in the ways in which the Ministry of Health contracts

its medical staff across rural areas, the findings and implications of which I discuss in the following section.

Contracting Health Services in Rural Areas

If geography, logistics and issues of state legibility impact upon the ways in which healthcare is provided to rural populations as I have shown above, they also influence the ways in which health professionals are recruited to practice in rural areas. Recognising that attracting health professionals to staff rural outposts is not without difficulty, the Ministry of Health currently operates a recruitment programme known as SERUMS or *Servicio Rural y Urbano Marginal de Salud* (Health Service in Marginalised Rural and Urban Areas). The SERUMS is a year long posting that obligates newly qualified doctors to work specifically in impoverished urban or rural areas upon completion of their medical training.

MINSA presents the SERUMS programme as an “enriching” opportunity, (MINSA, 2017) in which health professionals are able to offer their services to Peru’s poorest and most vulnerable populations, in exchange for the opportunity to experience first hand:

“The diverse social needs that our fellow citizens face on a daily basis and which vary according to their social condition, geographical location, and cultural and economic characteristics.”
(MINSA, 2017: my translation)

On their current recruitment webpage inviting applicants to sign up for the 2017 SERUMS programme, MINSA promotes the programme as an

“Invaluable opportunity for the health practitioner to enhance his or her professional training, to strengthen his or her social conscience and attitude both as a health professional and as a human being before Peru’s poorest citizens.”
(MINSA, 2017: my translation)

The programme urges applicants to join with the Ministry of Health in becoming

“Part of a great team working in different health establishments across (Peru) in order to embark upon the transforming changes leading the country to become a

healthier and more just society, united in solidarity” (MINSA, 2017: my translation).

However, my research reveals that behind the rhetoric, the reality is often very different for health professionals practising in rural locations. During my research, the doctor in charge of the *Posta* changed. A new doctor arrived to replace the one who had just finished the SERUMS programme. I was thus able to observe how two individual doctors carried out their work in a rural setting and established relationships with patients and actors in the local community. As a result, I witnessed first hand the different ways in which doctors are recruited, and in so doing gained insights that I may have overlooked had I not returned to Chiara for a second time. I learnt that the terms and conditions under which doctors are recruited into the SERUMS programme have a direct impact upon the work that they subsequently do; affects the level of care they are able to provide to rural populations and influences not only their personal perceptions of self-worth, but how they perceive the Ministry of Health to value and recognise their work. The case studies below, drawn from my fieldwork, illustrate such points.

I first met Doctor Jeanette in 2010 when she had recently begun her SERUMS posting and I arrived to begin my research. She was in her late twenties, from Lima, and did not speak any Quechua. However, she had specifically requested to complete her SERUMS in Chiara as her parents had been born there and had lived there many years before relocating to Lima before Jeannette was born. She still had relatives living in the village. Jeannette’s application to practice in Chiara had been successful and MINSA had allocated her a year’s placement in Chiara on a salary of some 4000 soles¹²⁵ a month. Jeannette was very happy with the outcome of her application: 4000 soles was significantly more than she could earn in Lima as successful applicants applying for remote rural postings are paid above the standard wages due to the remoteness of the clinic. Jeannette was given accommodation in the staff quarters behind the *Posta* as part of her contract, and given that she had no travel expenses to pay, she could effectively save the majority of her wages each month. Jeanette operated an ‘open door’ policy in the clinic: her patients could call and see her at any time, including outside of her working hours. Jeanette enjoyed particularly strong

¹²⁵ In 2018, 4000 soles is equivalent to approximately 880 GBP.

professional relationships with the elderly residents in Chiara, and periodically ran evening *charlas* or informative health orientated talks for them. The talks were designed to improve health outcomes for elderly residents, outcomes which were periodically evaluated by DIRESA via the monthly health consultation statistics all staff were required to send to the local health authority (Chapter 3). The events were always well attended, and the elderly residents seemed to enjoy them, regarding them very much as a social event rather than a purely informative health talk¹²⁶. Thus, Jeannette was generally well received by the *chiarinos*. Whilst they still referred to her as a *gringa* (slang for foreigner) because she was from Lima and not Chiara, she enjoyed a positive working relationship with her patients, evidenced by their welcoming reactions and gestures of kindness as she walked around the village visiting them. Very often, *La Doctora*, as she was affectionately known in Chiara, would be invited to eat breakfast or lunch with one family or another.

Doctor Manolo, who replaced Jeannette in 2011, had also arrived from Lima. In contrast to Jeannette, who had enthusiastically welcomed me to the *Posta* from the beginning, he did not seem overly keen on my presence at the *Posta* when I introduced myself to him. He told me immediately that I would not be able to observe any clinical practice and neither did he want me to stay in the *Posta*, as I had done when Jeannette was there, as he did not want problems with DIRESA, the local health authority. Manolo told me that he was in fact living in the *Posta*, as the new nurse, recently arrived from another town, had taken over the housing and kitchen area reserved for the attending doctor, to accommodate both her and her child. As a result, he had renovated one of the disused storerooms in the clinic and was living there.

Manolo continued, asking me where I ate in Chiara, as he had no kitchen or cooking facilities at all in the clinic. He told me that the one restaurant in Chiara, a living room in a neighbour's house that overlooked the main street, was frequently closed to the public and served a limited variety of food. I told him that I invariably ate with the *chiarinos* either in the Mother's Club a few doors from the clinic (Chapter 2) or by invitation or arrangement with the *chiarinos* in their homes. The doctor looked somewhat surprised, shrugged and said that he was reliant on having to travel to

¹²⁶ Attending several of the *charlas* with elderly residents I noted the striking difference in tone between Jeanette's sessions and the *charlas* which Juan Antonio and representatives of the *Juntos*

Andahuaylas on his day off to stock up on food supplies to last him until the following week. I urged him to speak to Honorata and Fortunata, two elderly *chiarinas* living opposite the *Posta*, who both Doctor Jeanette and I had gotten to know well through her evening talks with the elderly residents. They were always willing to cook us delicious meals for a small charge and in return for a good chat over a sugar-laden *mate* (herbal tea). I asked Manolo why he had chosen to practice in Chiara. He replied that he had been allocated the posting because “*salió en el sorteo*” (it came up in the raffle). I did not understand and the doctor did not seem keen to elaborate. I said my goodbyes and left him in his consulting room at the *Posta*.

The conversation related above was in the end, the only conversation that I was to have with Doctor Manolo. Shortly afterward, the new *Posta* nurse told me, as Manolo had suggested, that it was no longer possible for me to stay in the clinic and the doctor effectively cut all contact with me, refusing to allow me access to patient consultations, nor observe any of the work health professionals carried out in Chiara. In the same way that Rosalinda’s silence and polite refusals to talk to me (Chapter 4) had awakened my interest to learn more about her situation, Doctor Manolo’s refusal to allow me into the clinic or to engage on any level with me also prompted me to try to uncover why a doctor, who seemed rather unhappy in his new posting, would choose to practice in Chiara. His comment about a raffle still confused me and so, one afternoon I asked Doctor Grover, who had also completed a year’s SERUMS at the clinic in Izcuchaca at the beginning of his career, what Manolo meant. I learnt that rural service is allocated in two very distinct ways. Doctor Grover told me that the Ministry of Health places the names of all newly qualified doctors into a ‘raffle’ to decide who will be allocated which placement for their SERUMS. According to Doctor Grover, some 10 to 12% are allocated a paid placement, as Doctor Jeannette had been. However, for the vast majority of doctors, as their names are effectively pulled out of a hat, they are given unpaid placements as Doctor Grover explained:

“Twice a year there is a raffle. If you are lucky then you are given a place that is 24 hours from here, where you have no option but to stay there and so you have all your rights, including insurance covered, and they pay you very well. But if

programme ran for pregnant women in the village which were punitive in nature as I have discussed in Chapter 3.

you are not part of that initial raffle then you have to do (rural service) like I did: free of charge. What you can do is make an internal agreement with the health centre where you work, to contract you for more hours. Then, the health centre will pay you for those extra hours. That's what I did. For example, there were three hours a day that I had to work for free in the health centre. After that, they contracted me for another 5 hours and the pay was... well for the first 6 months they paid me 700 *soles*¹²⁷ a month. Maximum. Really it only serves to cover your transport costs.”

Whilst I do not know how much – if anything – Doctor Manolo was paid for his SERUMS placement, the fact that he was allocated the place as it ‘came up in the raffle’ suggests he was indeed one of the newly qualified doctors given an unpaid placement. In addition, poor working conditions, as Doctor Grover explains, compound the poor salary for the majority of doctors completing rural service:

“This is part of a system which has its failings ... because you are obligating this young doctor who has great expectations to complete rural service and you send him to a place where unfortunately he does not have the capacity to solve anything, because there is no medical equipment. There is nothing. Where...with four walls, a door and a roof they (MINSA) think that they are going to solve the health problems of an entire community. He does not have instruments, he does not have medication and the health insurance lets them (the local population) down.”

Thus, as a direct result of how the SERUMS are allocated, coupled with the conditions under which newly qualified doctors in rural areas are expected to live and practice, important issues of value and recognition surrounding their work come to the fore. Doctor Jeannette had applied and successfully obtained her desired rural post. She considered that the value of her work was recognised by the state: she was well paid, and was given comfortable accommodation. As a consequence, this affected her own perceptions about the usefulness of the work she was doing. She enjoyed her posting and went out of her way to nurture positive relationships with her patients in Chiara: she not only attended to her patients from behind her desk, but attended to

¹²⁷ In 2018, 700 soles is equivalent to approximately 150 GBP

them outside of her working hours, and actively sought them out visiting them at home in both a personal and professional capacity.

In contrast, Doctor Manolo has been assigned an unpaid post, in a remote location, which he knows nothing about. Neither has he been given accommodation. Forced to live in makeshift accommodation in a storeroom in the *Posta*, Doctor Manolo felt undervalued by the Ministry of Health. This translates into his relationships with his patients: remaining behind his desk all day he rarely ventures out into the village and finds it difficult to establish positive working relationships with the *chiarinos*.

His situation resonates with that of the young Papua New Guinean health worker whom Alice Street (2012) refers to in her article questioning the concept of care in public health service. She argues that apparent failures in care are often the result of the failure of the state and health services to recognise relationships between themselves and their workers. Like Doctor Manolo, the young health worker in her article had not been paid and was living in substandard accommodation: in a house without a kitchen. His co-workers had abandoned the health post reacting to conflicts with the community they served or responding to better offers of employment elsewhere. Not only was the health worker thus disheartened by the conditions in which he worked, but also by what these conditions communicated about how he was valued by others. For Street, the absence of his kitchen communicated to him that he was not viewed “as a person worth building a kitchen for” (2012:333): he is thus invisible to the local community he serves, the Ministry of Health and the state bureaucracy.

However, my research shows that issues of recognition and self-worth are not just confined to young, newly qualified doctors struggling in their first rural placement. In Peru, contractual problems extend beyond the initial SERUMS and are inherent in creating tensions between health professionals and widening fissures in an already fractured system, as practitioners must continue to vie for recognition of their work from the Ministry of Health as their career progresses. Once, the SERUMS programme is completed, doctors are contracted to the Ministry of Health as either a *contratado*: an employee with a fixed term contract, or a *nombrado*: an employee with a permanent contract. There are vast differences in the terms and conditions of each type of contract for doctors employed in rural areas as Doctor Grover explains:

“*Nombrados* work six hours. Well, in reality they work five hours because they have an academic hour for study. So they work five hours, they attend to six, seven or eight patients and then they lock the door, they close the health centre and they leave. Or they give talks to the community members and the health promoters and that’s their hours made up and they are paid. If they wish, they can do shift work or not, and they will be paid for these shifts. And afterwards, they turn the corner, where they have their house with a private practice inside of it...where they charge for consultations. They go to the health centres, they buy medication from them and then they sell them at double the price (*laughing*), there, in their private clinic. It is absurd. This is our way of contracting Doctors unfortunately. And we can’t do anything about these people because if you notice they have made a serious error, or a very serious error... and you try to report the error... the administrative process lasts months, years and sometimes is just archived without ever having been resolved”.

Obtaining a *nombrado* contract with its accompanying benefits¹²⁸ is thus the desired outcome for all health personnel. However, *nombrado* is more than just a permanent working contract; it is regarded amongst health professionals as a status symbol. Being accorded the title of *nombrado* – in English variously translated as named; renowned; famous; well known; - means that the doctor, nurse or obstetrician obtains a new working identity. The *nombrado* working contract bestows status, recognition and the corresponding workers’ rights upon the health professional.

Nombrados earn between 3000 and 3800 *soles*¹²⁹ a month and in addition receive private health insurance and a pension. Doctor Grover told me that their salary could be doubled from their earnings in private practice. Several doctors working in the MINSA run clinic in Izcuchaca also run private practices, Doctor Jorge amongst them. The clinics are located several minutes walk from the public health clinic. On several occasions I overheard doctors discussing health problems with patients and advising them to come and see them at their private practice for further treatment, claiming that the treatment they required was “not available” under their health insurance scheme.

However, such benefits and privileges also impact negatively on quality of care for patients. Doctor Grover believes that many doctors, once they have attained

¹²⁸ Benefits include a permanent job contract; a six hour working day; a month’s paid vacation; full pension rights and health insurance (Altobelli, 2008:3).

¹²⁹ In 2018, 3800 *soles* are equivalent to approximately 830 British Pounds, 3000 *soles* approximately 660 British Pounds.

nombrado status, effectively “wash their hands” of their public health duties. He describes their attitude as one of “it’s been a pleasure, now I’ve done my work and I am off to relax”, thus explaining Doctor Jorge’s attitude when refusing to undertake home visits to his patients in remote areas. Such findings are echoed in research by Webb and Valencia (2006: quoted in Altobelli, 2008:3) who report that:

“Entitlements and lack of accountability create a shield for minimal productivity and many refuse to do work they find disagreeable such as going out into communities”

Doctor Anibal also shares Doctor Grover’s concerns over quality of care amongst *nombrado* colleagues:

“(Quality of care) is a redundant question for a lot of people who have been in the Ministry of Health for years, who are employed on *nombrado* contracts, who are not even interested in such things. At the end of the day, they are going to get paid anyway. And if I, in my former position as Director of Quality of Care were to pass them a document, drawing their attention to something they have done...they can appeal against it, in short it’s very difficult to remove them from their post. It would have to be something extremely serious and a complaint about quality of care is not regarded as such. I had a lot of problems like that to deal with when I worked in that role. I tried to change their training, their mentality, but I got nowhere”.

Prior to obtaining their position as *nombrados*, Doctor Grover explained that these doctors will have spent up to ten years working 18 hours a day “killing themselves” as *contratados* (contracted employees) who work some 8 or 12 hour shifts and are paid between 2000 or 2500 *soles*¹³⁰ a month as Doctors and much less as nurses or obstetricians. Janeth told me that as a *contratada* obstetrician she earned around 500 *soles*¹³¹ a month. Unlike their *nombrado* counterparts, *contratados* do not enjoy the safety net of a permanent contract and are thus vulnerable to dismissal should complaints about quality of care surface, as Doctor Anibal explained:

“The *contratado* is at least susceptible to quality of care issues. When they are on a fixed term contract they have to do things well. They are going to treat their patients better, and work better besides. The *nombrado* doesn’t have to think about any of that”.

¹³⁰ 2500 *soles* are equivalent to 550 British Pounds, 2000 *soles* equivalent to 440 British Pounds in 2018.

¹³¹ 500 *soles* are equivalent to 110 British Pounds in 2018.

For Doctor Grover, such disparities in pay, working hours and attitudes lead to a culture where health personnel employed as *contratados*, remain in the job simply to become *nombrados*; at times, he believes, their only motivation to stay. For Doctor Grover, this has severe repercussions on working relationships between health personnel and also on their daily interactions with their patients:

“Nobody wants to even look each other in the eye. There are fights between doctors all the time: between *nombrados* and *contratados*. There are fights between doctors and nurses; there are fights between doctors and obstetricians; nurses and obstetricians *all the time*. And who wants to work in that kind of atmosphere? What’s more, what patient wants to go to a clinic where the working atmosphere is like that? If the first thing they hear is: (*imitating the patient*) “Doctor, Good morning”, (*shouting, imitating an angry doctor*) “Sit down!”

Quality of care in health consultations is thus compromised as a result of fractured relationships between health personnel working within the boundaries of the hospital environment. However, as Doctor Grover attests, these fractured relationships occur precisely because of the way in which practitioners are contracted to the Ministry of Health. Notions of value and corresponding status underscore the work of *all* doctors as they progress through their career within the Ministry of Health: from Doctor Manolo’s negative experiences and his own perceptions that the Ministry of Health undervalues his work as a newly qualified participant in the SERUMS programme; Janeth’s continued low salary and lack of benefits as a *contratada*; through to Doctor Jorge who, having attained his much sought after *nombrado* status, refuses to travel to attend to patients in their community, believing his elevated status excuses him from such work. Thus health providers suffer due to inequalities inherent in the terms and conditions under which they are employed, and the refusal of the state and the Ministry of Health to recognise meaningful relationships with its workers.

Conclusion

This chapter has examined the ways in which geography, logistics and notions of state legibility intertwine to shape the work of health professionals providing maternal healthcare to rural populations in the Andes. Geography influences health policy

directives, with rural populations becoming classified as problematic by virtue of the access difficulties associated with their remote location. However, as anthropologists have shown, access problems then become translated into ‘problematic traits’ inherent in rural populations (Street, 2016): for example, in the Andes, the Ministry of Health measures rural populations’ access to maternal health not solely via geographic location, but also by ethnic, educational, cultural and socio-economic markers (MINSA, 2010; 2017). Labelled culturally and ethnically as ‘problem populations’ (Taylor, 2007), rather than simply populations with access difficulties, rural women then become the focus of targeted maternal health interventions.

In the Andes, geographical remoteness from the clinic and the logistical difficulties in travelling to it mean that those rural women rarely visit the clinic. Such women, living on the periphery of healthcare provision, thus “slip through the net” remaining largely outside of state purview. These women are thus able to avoid the monitoring and surveillance strategies put in place to monitor their reproduction. In response, Peru’s Ministry of Health has harnessed its workers to render these populations visible through the implementation of multi-sectorial approaches and outreach strategies requiring that health professionals must attend to rural patients across a range of disciplines in one visit to the clinic. In addition, service providers must travel to isolated communities to actively seek out and enrol eligible patients within the SIS insurance scheme operating out of state run clinics. Thus, we see a subtle shift in policy: rather than patients being responsabilised to access clinical spaces (Chapter 3), health service providers are now charged with bringing the clinic to them, in effect working ‘in the field’.

The necessity of such strategies challenges dominant Foucauldian interpretations of power-vision and governance emanating from a homogenous state apparatus (Kierans, 2015; Mosse & Lewis 2005; Li 2005; Ferguson & Gupta 2002; Rankin 2001), questioning the ability of the state to be ‘all seeing’ (Street, 2012; Casper and Moore, 2009; Scott, 1998). Outside of Anglo-American settings, where the ‘counting systems’ of the state apparatus are clearly defined, the state must rely on its workers to render ‘hidden’ populations visible.

This approach has widened fissures in an already fractured system: disciplinary consequences are forthcoming for health professionals should they fail to provide the

full range of services available to the women, further revealing the biopolitical underpinnings to the new strategy. Obstetricians must be meticulous in recording consultations, in order to avoid the thoroughness of their work being called into question by DIRESA, the local health authority. If procedures are not correctly followed or documented, obstetricians may face investigation, fines and possible dismissal.

Aside from shaping service providers' perceptions of rural populations and the targeted strategies employed to provide for their maternal healthcare, geography and logistics also shape how service providers are recruited by the state. The Ministry of Health operates the SERUMS programme: a yearlong contract, which all newly qualified doctors must undertake in rural areas. Marked differences are apparent in the ways in which the state recruits participants into the programme with some doctors awarded paid placements and others, selected at random from a raffle, assigned unpaid placements. Such recruitment discrepancies lead to doctors questioning the value and recognition the Ministry of Health places upon their work. Disillusionment in turn impacts negatively on the quality of patient care afforded to rural populations.

Issues surrounding the perceived value of a service provider's work and the recognition they are granted from the state continue throughout the course of the health professionals' career. Tensions and fights are commonplace amongst *nombrados* and *contratados* (fixed term and permanently contracted staff) as contractual inequalities cause them to vie with each other for career advancement in a fractured and overburdened system.

In investigating how geography and logistics impact upon maternal health this chapter has done so from the vantage point of the clinic. In the following chapter, my final data chapter, I move beyond the clinical spaces of the MINSA public health system to investigate maternal health practices taking place in the homes of rural women. These practices remain outside of state purview and make up the backbone of the community *partera* (midwife)'s work.

Chapter Seven: Resisting clinically managed birth: delivering outside of state purview

Introduction

In Chapter Five of this thesis I examined how the Ministry of Health mobilises family members to encourage rural women to agree to a clinically managed birth. Chapter Six showed the access difficulties that both rural women and health professionals face when geography and logistics intertwine to complicate clinically managed maternal care. For many rural women, reaching the clinic presents difficulties. Accordingly, the state responsabilises health professionals to ‘bring the clinic’ to their patients, travelling to remote populations to attend to their healthcare needs *in situ*. This chapter, my final data chapter, will build upon this work, to explore maternal care practices which continue to take place outside of the clinic, despite the current prohibition on *parto domiciliario* (home birth) in rural areas of the Andes. In so doing I will expose the gaps in the state’s intercultural healthcare initiative: home births represent a continued cultural challenge for the Ministry of Health, taking place outside of state purview, in the privacy of the home where the interculturality initiative cannot reach.

I begin by examining the role of the *partera*, or community midwife, a key figure in home based maternal care. I give a brief historical overview of her role, highlighting her previous importance as an interstitial figure, ‘bridging the gap’ between state and citizen in the interstices of maternal health, before discussing the implications for Andean women and health professionals in light of her current unrecognised and illegal status in Peru. Narrative interviews with a MINSA trained obstetrician and a community *partera* with many years of experience, challenge the Ministry of Health’s current prohibition of the *partera*’s work, and question how the state delivers ‘intercultural’ healthcare to rural populations who continue to use the *partera*’s services.

I then discuss the work of the *partera profesional*, or professionally trained midwife, an emerging maternal health provider in Peru who offers a small scale but bespoke service to women who have opted to resist clinically managed birth. Here I draw upon

a narrative interview with Ruro, a former MINSA trained obstetrician who has set up her own practice in Cusco. Her work exposes many of the cultural assumptions underpinning MINSA's current maternal health policy, and the contradictions at play as despite being a professionally trained obstetrician, like the community *partera*, Ruro is currently forced to operate her practice at the margins of the law.

Ruro is not the only health professional I encountered to resist clinically managed birth. The following section of this chapter presents Yesica's story. As a *Posta* nurse in Chiara, and pregnant with her first child, Yesica, like Ruro and her patients, also chooses to disregard MINSA's *parto institucional* policy and give birth at home. Yesica's story highlights important considerations and further contradictions inherent in medical practice when delivering under current maternal health policy directives and offers a dual perspective on home birth, as Yesica is both a health professional *and* a pregnant *chiarina*. I end by summarising the contributions of this chapter, drawing particular attention to the way in which Andean women, *parteras*, and health professionals by choosing to deliver at home, continue to resist state imposed clinically managed birth. In so doing, I highlight the changing nature of the relationship between (a minority) of health professionals, *parteras* and their patients, as they find ways to work together to allow rural women to continue to deliver their children outside of clinical spaces.

Delivering at the margins of the law: the changing status of the *partera*

The community *partera* or midwife in Peru – as elsewhere across Latin America - cuts a controversial figure: for rural women she plays an essential role in facilitating home birth (Siqueira et al., 2006; Chávez Álvarez et al., 2007; Murray de López, 2016), yet her work is enmeshed in the biopolitical machinations of the state apparatus (Murray de López, 2016). Continually caught up in the myriad U-turns in reproductive and maternal health policy in Peru (Chapter 1), the Peruvian *partera* has suffered a chequered history in her relationship with the state.

Global Primary Healthcare (PHC) models adopted from the 1970s acknowledged the significance of traditional healers and midwives for local populations and regarded them as a means to connect with isolated, rural communities. Endorsed by the World Health Organisation (WHO), between the 1970s and 1990s, the PHC approach was to

identify key traditional healers and Traditional Birth Attendants (TBAs) and train them in biomedical practices in order to ensure biomedically orientated healthcare reached those communities most in need. TBAs were thus trained as health auxiliaries and promoters in Peru, as elsewhere, within local communities to attend to the shortage in staffing and health resources. The intention however, was not to recognise their skills and local knowledge as comparable to biomedical practices (Sesia, 1996; Pigg, 1997). Rather, TBAs were harnessed to combat high maternal and neonatal mortality rates across the global south.

Anthropologists focusing on cross cultural critiques of reproductive health have highlighted the propensity of national governments to marginalise the work of TBAs and other local healers (Jordan, 1992; Sesia, 1996; 2007; Pigg, 1997; Berry, 2006; 2013), despite evidence that midwifery, understood as a professional practice, continues to “offer a vital solution to the challenges of providing high quality maternal and newborn care...in all countries” (Lancet, 2014: quoted in Murray de López, 2016). Stacey Ann Pigg (1997) has noted that the continued use of terminologies such as “traditional birth attendant” and “skilled birth attendant” permit national governments to define who they want their health workforce to be. Whilst such terms are employed in the spirit of cross cultural sensitivity and flexibility, Pigg (1997) argues that they nevertheless allow national governments to maintain inequitable health structures and permit biomedical discourse to dominate national policy making and health practices. Certainly, in Peru, between 2001 and 2005, the work of the *partera*, came under scrutiny of government sponsored public health research (see Ybaseta-Medina, 2011) carried out both nationally (Benavides, 2001; MINSA 2003; MINSA, 2004a), and specifically in rural areas (MINSA, 2004b; Ybaseta-Medina, 2011).

The research, aiming to assess how best to reduce the high maternal mortality statistics of the era – estimated at 163 deaths per 100,000 live births in 2002 (MINSA, 2004a) – sought to establish links between the work of the *partera* and incidences of maternal mortality (Ybaseta-Medina, 2011:11), drawing attention to the high MMR particularly in impoverished rural areas of the Andes where the *partera* traditionally carries out her work attending to home births (ibid). Government sponsored researchers acknowledged on the one hand that the *partera* could contribute to the

reduction of maternal mortality rates in rural areas *if* given training on how to attend to a delivery in a sanitary manner (Benavides, 2001; Ybaseta-Medina, 2011) and also become a “strategic ally” (Ybaseta-Medina, 2011:11) for health service providers in rural areas were she to act as an intercultural nexus between community women and health services, yet the same research also attributed the *partera* as being responsible for delays in referring a pregnant woman presenting with complications to her nearest health establishment. In this way then, her work was reported to contribute to MMR (Benavides, 2001; Ybaseta-Medina, 2011).

My research supports Benavides’ (2001) assertion that the *partera* not only formed an important link between health service providers and the community in Peru, but also that health professionals were willing to, - and in fact did - work closely with the community midwife. Discussing the role of the *partera* with Janeth during a quiet lull in the night shift in Izcuchaca in 2012, Janeth affirmed the importance of the work of the *partera* for Andean women, explaining they were usually their first choice for maternal healthcare and in her view, had historically formed an extremely important link between the pregnant woman, her community and the health services:

“... in the communities furthest away from the cities, the work and influence that the *partera* (community midwife) had or the *curandero* (shaman) had ... the link between health, the health professionals and the community was the *partero*. It was the *partero*, or sometimes the *promotor* (community health promoter) or the *curandero*. Before coming straight to us they used to go to the *partero* or the *promotor* or the *promotor* would come to us. But it was never a question of a direct link, even now: very rarely. There are very few patients as you have seen that come straight to us and talk to us”.

Thus, the *partero/a*¹³², the *curandero/a* and the community health promoter, who was always a local resident of the village, were an essential nexus and communication channel between community residents and the health clinic (Farmer et. al., 2013) prior to the move to institutionalization of childbirth in Peru in 2009. Janeth recounted her experiences of working closely with community midwives in 1996 in Huayrocondo,

¹³² The community midwife in the Andes is usually referred to as a *partera* reflecting her female gender, but here, Janeth’s reference to the *partero*, would denote a male midwife. For this reason I have chosen in this instance to describe the community midwife as both a male/female profession in Spanish.

an Andean village in Cusco province, during her SERUMS, her year of obligatory rural service:

“We have always asked that the *parteras* be our allies, we have never asked that they be prohibited (from practicing). But for the whole time that I have been here, since coming here (to Izcuchaca) I have never worked with a *partera* because nowadays there just isn’t that type of specialist *partera* anymore. But there was in Huayrocondo in 1996 when I did my SERUM. I used to take her with me when there was a birth, but she didn’t used to attend to the birth, but what she did was try to work with us. She would come to find me, she would call me, and I would go with her. We used to go out at four in the morning because I lived in Huayrocondo and I used to go and attend to the births there. But now that we are prohibited from attending to home births, as a result these *parteras* are rejected. But they don’t want to work alongside us either. No. Before, we used to train the *parteras* and the *promotores* showing them how to manage a clean birth. We don’t do that anymore because birth must not be managed at home, it must take place here, in the clinic. If the *promotora* wants to be present at the birth, she can be, but she cannot touch the patient. Things have changed a lot. Before, yes, we used to train them, we used to give them a little case with gauze, with cutting instruments, with clean Gillette blades to cut the cord, we used to give them all that. And then they had to bring the patient to the clinic or let us know, but not anymore. Nowadays they only have to check that the patient is looking after herself during pregnancy, when her labour pains begin they have to call us to warn us they are bringing the patient in ... the pregnant woman, nothing else; not anymore. When I was in Huayrocondo I used to work very closely with the *partera*. But then I was attending to home births; I’m talking to you about 1996. But not after that date, all of that was prohibited. I mean, if I were to work closely with the *partera* today it would be to get her to tell me how many pregnant women there are (in the community), or if the pregnant woman...if any patient that has the baby lying in the wrong position has been to see her to perform *manteo*¹³³, because that is prohibited as well. So now we have to give the *partera* advice, tell her “No, you can’t do that”. Give her reasons why not, you know? The thing is ... there were always quite a lot of infant deaths with the *partera*, a fair number of neonatal deaths. Sometimes there was maternal death too. So, because the maternal and neonatal death rate was very high, (the Ministry of Health) has employed other strategies, that seem to be working...you know?”

Whilst in 1996 then, Janeth was able to work in alliance with the *partera*, her status in Peru was about to change. That same year, TBAs, whether trained or untrained, became excluded from the World Health Organisation’s definition of Skilled Birth Attendants (Berry, 2013), relegating the status of the Peruvian *partera* to an unrecognised traditional practitioner, unregulated in her profession. The Peruvian

state's signing of the Millennium Development Goals (MDGs) in 2000, committed Peru to reducing maternal mortality by two thirds by 2015 under the terms of MDG5 (UNICEF, 2017). Key in the MDG5 guidelines was an emphasis on Skilled Birth Attendants (SBAs) being present at delivery¹³⁴ (WHO, 2012b; van Dijk et al., 2013; Kvernflaten, 2013) and an emphasis on access to Emergency Obstetric Care (EmOC). As a result, many countries across the global south, - Peru included - moved towards favouring facility-based childbirth care over home-based care (Ronsmans and Graham, 2006; PMNCH, 2010). As anthropologists have noted, health facilities, with their overarching emphasis on the 'biomedical', tend to discount cultural influences (Camacho, Castro and Kaufman, 2006; van Dijk et al., 2013). Whilst some Latin American health authorities continued to acknowledge that *comadronas* (community midwives in Guatemala) are in close touch with the maternal health needs of the indigenous population in rural areas (van Dijk et al., 2013), and are still regarded as a medium to improve maternal and infant health (Hinojosa, 2004), in Peru, because the *partera* no longer met the WHO's criteria to be classified as a SBA, her work was no longer officially sanctioned. Stripped of her status, by 2009 when the Ministry of Health published its new Reproductive and Sexual Health Strategy (MINSA, 2009), which effectively prohibited home births across the country, the *partera* was also prohibited from practicing. As a result, *parteras* who continue to operate in rural areas of the Andes currently do so at the margins of the law.

Officially rejected as a viable maternal healthcare resource by the state and the Ministry of Health then, and currently unable to legally attend to home births – or indeed accompany their patients during *parto institucional*, their role has been reduced to one of being an information channel between obstetrician and patient, reflecting the findings of ethnographic studies in Nicaragua (Kverflaten, 2013) and Guatemala (Van Dijk et al., 2013). Today, the Peruvian *partera* is simply expected to inform the clinic of any pregnant women in the community and to monitor these women ensuring their pregnancy progresses smoothly in the obstetrician's absence.

¹³⁴ Skilled attendance refers to services offered by an accredited health professional (midwife, doctor or nurse), who has been trained in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. In addition these health professionals need to be supported by appropriate policies, essential supplies including medicines and operating under appropriate regulatory frameworks (WHO 2012b).

Traditional practices such as *manteo*¹³⁵, - the rotation of the foetus in the womb through shaking the pregnant woman in a blanket and applying massage techniques - (Figure 27) usually performed by the *partera*, are prohibited and it is the duty of the *partera* to inform the clinic if any women have requested this service from her. Thus, the emphasis has shifted from the *partera* playing a key role in birthing practices in which she worked closely with the obstetrician to support the local community, as Janeth has suggested, to one in which she is very much placed at the margins, where her role is purely informative.



Figure 27: *Manteo*: rotating the baby in the womb. Source:
<http://bartolinas.blogspot.co.uk/2010/09/parto-ancestral-al-rescate-del.html>

Hence once formerly regarded as an interstitial figure working at the intersections of maternal health where the state and citizen meet, the marginalisation of the *partera* from all aspects of delivery and her complete exclusion from clinical spaces raise important questions about how the state currently problematises, manages and

¹³⁵ *Manteo* is the word used to describe the Andean practice of rotating the baby in the womb to reposition it if it is lying in the wrong position. The pregnant woman may lie down in a *manta* or blanket, or have the blanket wrapped around her abdomen. The *partera* repositions the baby by shaking the blanket and using massage techniques. (Figure 27).

intervenes in intercultural healthcare in Peru. Definitions abound across the Latin American public health literature as to what ‘Interculturality in Health’ entails (PAHO, 2017; MSPAS, 2009; Mignone et al., 2007; Salaverry, 2010; van Dijk et al., 2013; Muñoz Bravo et al., 2013), yet all highlight the need for open dialogue, mutual respect and recognition of the work carried out by both practitioners operating in health establishments and community practitioners, (such as *parteras*) in order to achieve more equitable and participatory healthcare access for local populations (PAHO, 2017). In addition, Guatemalan health authorities have highlighted that intercultural services ought to be conceptualised, organised, and implemented while taking the indigenous people’s worldview as a starting point, thus adapting to and respecting indigenous people’s way of life (MSPAS, 2009). The direct prohibition of the *partera* from carrying out her work in Peru disregards the maternal health practices essential to Andean women, and overlooks the broader social function the midwife fulfills as a community member (van Dijk et al., 2013; Murray de López, 2016). In devaluing her work in this way, the Ministry of Health thus sends the clear message to Andean women that obstetric clinically managed birth is somehow ‘superior’, whilst home birth with a *partera*, culturally and bio-medically deficient. Promoting ‘Interculturality in Health’ on the one hand, the Ministry of Health nevertheless views the Peruvian *partera* not as an asset to intercultural healthcare, but rather as an obstacle to it.

Several anthropological studies carried out in the global south have noted the tendency to problematise indigenous cultural practices via the role of the *partera*. Even when local midwives and healers have been regarded as a health resource rather than an obstacle, ethnographers have highlighted the propensity for programme organisers to devalue local knowledge. For example, Stacey Ann Pigg’s ethnographic work in Nepal (1995) on incorporating local realities into intercultural development plans, concluded that programme leaders scrutinised and judged local beliefs around birth, whereas obstetric knowledge was presented as unassailable. Neither was there room for intercultural dialogue or an exchange of ideas. Hence, Pigg argues, development institutions place themselves as the locus of authoritative knowledge, while devaluating local forms of knowledge, through use of markers such as ‘traditional’. (Pigg, 1995). In Guatemala, Sheila Cosminksy (2001) and Servando Hinojosa (2004) described how *comadronas* have been trained in biomedical

knowledge and practices, in order to ‘reach’ indigenous populations. Unidirectional and hierarchical, this training privileges the biomedical system, disregarding the *comadronas* opinions.

As I learnt more about the current prohibition of the *partera* and her work in Peru, I tried to seek out a practicing *partera* to ascertain her opinions and learn more about the cultural aspects to her work. In Chiara, I had tried to talk to Marina - an elderly woman well known amongst the *chiarinos* as a former *partera* - about her experiences over dinner one evening, but she had laughed and said, “Oh, that was all such a long time ago”. Her husband, had been quick to intervene, repeating that she had not practised for years and that these days “people are almost afraid” to talk about the *partera* and her work given her current semi-legal status, officially unrecognised by the government or Ministry of Health. However, in 2012, Janeth, the obstetrician whom I worked most closely with in the clinic in Izcuchaca, told me about an upcoming conference in Cusco on Andean Medicine and it was through my attendance at the conference that I came to meet Eva, a practicing *partera* working in Cusco.

Eva’s story: Cultural practices and state rejection

Eva is a 67-year-old *partera*, who began learning about Andean medicine at the age of eight, from her father, a *curandero*. Watching him closely, she soon learnt how to offer *pagos a la tierra*, rituals offered to the *Pachamama* or Mother Earth in thanksgiving for her generosity (see Bastien, 1985, 1998; Arnold and Bastien 1989; Sikkink, 1997; Gianotti, 2004; Bolin 2010; Harris, 2016). Next she learnt how to assist women giving birth and by the age of 12 she had learnt everything from her father and began to practice Andean medicine herself.

Eva and I met on the outskirts of Urubamba, a town located in Cusco’s Sacred Valley. Alternative medicine is popular in the town and several *curanderos* have set up consultation areas in their houses. Here in familiar surroundings, Eva was keen to share her knowledge with me, explaining in detail the cultural practices her work entails. She began by explaining that a *partera* will monitor the progression of a woman’s labour by checking the time between her contractions and giving her *mate* to

drink, a herbal infusion made from *mejorana*, a local plant, to help advance her labour. She describes her work as playing a supportive role for the woman in labour:

“The only thing that I do, as we are in the countryside, is...place an animal hide on the floor, no? Then I attend to the patient whilst she is kneeling down. Once she is kneeling, you just have to support her back and her stomach a little, that’s all. You help little by little, massaging her, as the baby works its way down. Then she gives birth quickly because she is kneeling with her legs open and she doesn’t suffer much. And that is now I help her give birth.”

Eva spoke at length about the plants and herbal remedies used after birth to help the new mother make a quick recovery and the procedure she followed immediately after birth:

“After the birth, you give her another herb to help the blood which is accumulating inside to leave the body. The patient has to do exercise too – she has to stretch out on the bed and she has to be massaged. Why? So that all the bad blood can come out, no? So that (the womb) is left empty”.

Eva’s words echoed closely what I had observed in the clinic in Izcuchaca and also in Chiara when Rosalinda had given birth. There was no herbal tea administered, but new mothers had been encouraged to stretch out in their beds and the attending obstetrician had shown them how to massage their womb, to stimulate blood flow and encourage it to return to normal size as soon as possible. For Andean women, it is particularly important to manage the expelling of this “bad blood” in the correct manner as it is considered ‘alive’ and if handled in the wrong way, is potentially harmful. Eva stressed the importance of managing the flow of blood by the careful administration of particular herbs, drawing on the Andean illness classifications of hot and cold:

“You cannot just give (the new mother) any kind of infusion, you can’t give her things like that because sometimes the blood that she is expelling is alive. It can clot inside her and then it stays there. That’s how tumours are formed and that type of thing. To expel the blood you have to give her *mate de quisa* (an Andean herbal tea): this purifies the blood, it’s an anti-inflammatory and it helps the blood leave the body, all of the clots, everything that has stayed inside comes out...the blood has to flow well so that everything is left clean because when we have given birth the body is like a thorn, everything is open and bleeding and so anything hot that you put inside ...well, what happens? It tries to cook inside and it won’t come out, it doesn’t clean up like it should”.

Eva's words highlight practices associated with Andean aetiology, which considers extremes of hot and cold to be dangerous (Larme and Leatherman, 2003). Such extremes are to be avoided to prevent post-natal complications; thus the choice of tea administered to a new mother is extremely important (Van Dijk et. al., 2013).

The work of the *partera* continues after delivery and immediate *post partum* care. Specific practices are carried out in the weeks following birth, when the *partera* fulfils a social function, regularly visiting the new mother at home to support her post natal recovery. The new mother is given *caldo blanco*, a white broth, taken to help her regain her strength: variations of which appear in the narratives of women such as Elena who lamented the fact that her husband was unable to bring her any *caldo* after she had given birth to Soraya her daughter in the hospital in Andahuaylas (Chapter 4). For Andean women, a post natal bath in an infusion of local herbs and flowers is important, in Peru, usually taking place 15 days after the birth. This is followed by the *fajado*, or binding of the body in cloths enveloped in a mixture of herbs and fluids. Eva explains:

“You have to give (the new mother) her bath, then her *fajado* (binding). You bind them so that after the birth they don't suffer pain...you mix together herbs, you let them dry out, you grind them and you macerate them with a little bit of ... with a bit of *siete harinas* (a mix of seven different types of flour). You put them all in the bathtub along with other herbs, which need to be included as well. You add a few other bits and pieces, you need to know what, but it's easy to do. Then everything goes back to normal: the parts of the body that have been opened to give birth knit together again and so (the woman) won't have problems.”

Eva's descriptions, explanations and experiences show us clearly that Andean women continue to value the socio-cultural role that the *partera* fulfils, in carrying out her *post partum* home visits. As I have detailed above, pregnancy, birth and motherhood in the Andes involve a series of very specific local practices. Whilst the Interculturality in Health initiative encourages *parto vertical* (vertical birth) in MINSA clinics as a move towards increasing cultural empathy (Chapter 1), many other practices essential to Andean women such as the particular drinks, foods, bathing techniques and subsequent home based *post partum* care are not catered for within the remit of MINSA's Interculturality in Health strategy. Such practices form

the backbone of the *partera*'s work. Yet, just as the *partera* is forbidden in MINSA clinics, her practices are also forbidden within clinical spaces.

Nevertheless, although Andean women must currently give birth in an obstetric clinic, they continue to utilize the services of the *partera* outside of the clinic for delivery and to provide post-natal care in line with their traditions and customs. Hence, despite the state denying her officially sanctioned recognition of her work, the Peruvian *partera* continues to work, albeit clandestinely. Eva told me that so many women required her services that she does not need to advertise; women will simply seek her out through word of mouth. At times she has to 'escape' just to be able to go to work otherwise the women "would have me stuck at home all day attending to them and I can't do that all day".

Rural Andean women then, like their Mexican counterparts in Jenna Murray de López' ethnographic study (2016) continue to navigate between local and obstetric knowledge systems to meet both biomedical and biosocial needs of pregnancy (Murray de López 2016). Anthropologists have argued that "communities who are tied to multiple and non-local systems" (Abu-Lughod, 1990:42) use a variety of practitioners as a means to circumvent the undesired aspects of the public health system (Unnithan-Kumar, 2001; Smith-Oka, 2012b; Denham, 2012). Maya Unnithan-Kumar (2001), in her ethnographic work on reproductive rights in Northern India argues that the way women talk about managing their maternity suggests that any active resistance to clinically managed birth is arguably a secondary unintended outcome (2001). Rather, she suggests that their use of a mixed economy of care is a way of incorporating bio-social knowledge and beliefs about bodies and maternity, family and social values and competing notions of risk.

Whilst Andean women then are prepared to access mixed economies of care to meet their maternal health needs, Eva, as a practicing *partera*, was somewhat more scornful of a pluralistic maternal health approach. Contrary to Janeth's opinion that obstetricians working in MINSA could again perhaps work hand in hand with *parteras* in a complementary partnership to enhance patient care, Eva was resistant to this idea:

"I don't think so. I don't think that the doctors or the nurses would accept it. They are very selfish and due to this, if anything were to happen, they would try to place the blame elsewhere, saying that the *parteras* were responsible for the

death. No. I wouldn't be in agreement with this idea because there are some of us who attend births now and after the birth the woman goes to get the birth certificate for the child and everything and they say to her "Why did you give birth like this?" Why this and why that? They say all sorts to her, they start insulting her, sometimes they shout at her and that's why they are afraid. Neither would I like to attend with them, because medics don't have much patience. No they don't. They say that we are going to take work away from them, and they won't get anymore work. I think they think like that, selfishly. They don't say, "Well, that's ok. Where did you give birth? It's ok. We will give the certificate to you". No. In other words, it's a little difficult to get the necessary paperwork. Sadly, we can't give out birth certificates because we work in secret as they say, you know? We aren't recognised by the authorities, we don't work officially, and we don't have an office or ranking."

Hence, despite Andean women and their families affording social status and trust to *parteras* to fulfill the cultural aspects of maternal care still missing from government initiatives, Eva's words highlight that their greatest challenge lies in the refusal of the state and medical institutions to see *parteras* as equal partners in the provision of quality reproductive and maternal healthcare. The diminished status of *parteras* like Eva in Peru is reflected in recent ethnographic research across Latin America (Berry, 2005; 2006; 2013 in Ecuador; Kvernflaten, 2013 in Nicaragua; van Dijk et al., 2013 in Guatemala; Smith-Oka, 2012, and Murray de López, 2016, in Mexico). Kvernflaten's 2013 ethnographic study in Nicaragua, highlights how – as in Peru - changes in the law have prevented TBA's from working legally and as a result many expressed their disenchantment, reporting feelings of dissatisfaction and low-self esteem, as they perceived the state to undervalue them and their practices (Kvernflaten, 2013). Jenna Murray de López (2016) has noted that the legal position on attending births outside of medical institutions in Mexico is "complex and contradictory" (2016:287). She points out that whilst in theory a woman has the right to choose where she gives birth, delivery cannot be legally planned outside of a medical institution. Where homebirths are recorded in Mexico, they are done so as if they were an emergency and there was no time to reach a hospital, reflecting scenarios present in Yesica's story, presented later in this chapter. Women in Mexico who give birth at home using a local *partera* will take the baby to a public clinic a few days later where a licensed medical professional will register the birth as a spontaneous delivery at home (Murray de López, 2016:287). Her findings reflect the current situation in Peru: because the state does not recognise the work of *parteras*, in order to obtain a birth certificate for a

new-born child, the child's parents must present proof of the baby's birth having taken place in a clinic. The attending obstetrician or lead practitioner in the delivery signs a document, and the baby's details and footprint are recorded on the document, which is then stamped with the official seals of the clinic. However, as Eva indicates, when women who have not given birth in a clinic bring their baby to the clinic in order to obtain the necessary documentation to allow them to register the birth legally, the medical personnel on duty often question them and make things difficult for them. I witnessed such a situation in Izcuchaca, when a woman who had not given birth in the clinic brought her baby to be registered. The nurse on duty questioned her at length about the details of the birth and chastised her for not having given birth in the clinic, telling her she was unable to issue the necessary documentation to obtain a birth certificate. When I asked Janeth what would happen, she told me that eventually the clinic would issue the documentation but they would make the woman wait in order to inconvenience her. The idea being, according to Janeth, that she will think twice before giving birth outside of the clinic in the future. Eva also told me that ultimately the clinics must provide documentation if the woman brings her baby:

“They can go to the hospital to register the baby because they can't prohibit them from doing it. They can't prohibit this because it is the right of every person (to have a birth certificate). They make it difficult because they don't want women to give birth at home but at the same time they don't want to start prohibiting them from coming to the clinic either”¹³⁶.

The example above illustrates how women in the Andes do not necessarily employ mixed economies of care - moving between Andean approaches to childbirth and modern day obstetrics - through choice but rather, because of the way the state governs the health system, they are forced to do so. The way in which the current maternal healthcare system is organised means that even when Andean women do give birth at home, contrary to maternal health policy, they must still access the obstetric-based system in order to register their child's birth. Despite Eva's protestations that the two systems are unable to work together in harmony,

¹³⁶ A recent change to the law reflects Eva's opinion. As of 2016, all children born in Cusco province must be registered within 24 hours, regardless of whether they were born at home or in a clinic. Health professionals are no longer permitted to withhold documentation preventing a child's parents from registering the birth. Directiva no. 001-2016 GR-DIRESA DE AIS “Directiva administrativa intersectorial para la identificación y afiliación oportuna del recién nacido al seguro integral de salud SIS en la región Cusco” (MINSA, 2016)

nevertheless we can see that Andean women must negotiate their way through both systems as each provides for their needs in different ways. Modern obstetrics provides for safe delivery with specialist care but currently falls short of providing the full range of post-partum practices, which Andean women consider to be culturally important. *Parteras*, despite lacking official recognition and status from the state, continue to meet the socio-cultural needs, - albeit clandestinely - of Andean women, allowing them to give birth at home in addition to receiving and participating in the post natal care practices that have formed part of their heritage for many years. However, it is modern obstetric practice, which facilitates their access to the present-day Peruvian state, its bureaucracy and representative institutions. To legally register their child – and thus entitle the child to its corresponding rights as a Peruvian citizen – they must obtain the necessary paperwork from an official health establishment. Thus, whilst, Eva's words point to a difficult relationship between 'traditional' Andean approaches and 'modern' obstetric approaches to maternal health: Andean women *must* employ a plurality of approaches to successfully negotiate their way through the competing discourses emanating from cultural and institutional understandings of maternal health.

Today in Peru, community *parteras* do not provide the only alternatives for rural women seeking to avoid clinically managed birth. Although, like *parteras*, their legal status is called into question because of the state's insistence that all birth in Peru is to be clinically managed, nevertheless there are a small number of private *casa de nacimientos* (birthing houses) operating in and around the Cusco area. Such *casas* present themselves as private clinics offering rural women and their families antenatal services. The state decrees that licensed health professionals must manage these clinics, and where births take place in such establishments, they must nevertheless be registered as home births (see also Murray de López, 2016, on Mexico). Still very much a marginal alternative for Andean women, their existence nevertheless challenges official MINSA policy. For this reason, it is worth casting an ethnographic eye in their direction. In the following section I discuss Ruro's story, a MINSA trained obstetrician who, disillusioned with the way in which maternity was managed within the state run system, decided to open her own *casa de nacimiento* operating from the environs of her own home.

Ruro: resisting through humanized birth

Ruro began her medical training in general nursing where she learnt the basics about obstetrics and she decided to specialize in this field. Her obstetric training coincided with her first pregnancy and she quickly became disillusioned with the way modern obstetrics managed childbirth:

“I could not conceive of how a birth could be so violent, it made me sad and I said to myself... “I should have found this out before I got pregnant” ... it seems like a punishment or something like that. When I went out into the street and I saw a pregnant woman I used to think about everything that the poor woman would have to endure, or I saw a woman who had already had her baby and I would say to myself “wow!” thinking about everything that she had gone through. It seemed to be something very difficult, something ... extremely terrible, and I used to compare it to my mother’s delivery”.

Ruro’s mother had given birth at home and Ruro had assisted the *partera* in the delivery of her younger sister. The *partera* had cared for her mother throughout her pregnancy, helping her prepare for the birth. Consequently, shocked by the “insensitivity” of the obstetricians she had witnessed attending births during her training, Ruro decided to forego her antenatal care:

“I worked for 8 months without having a check up because I knew what was involved, how they work in the health centres. I did not want anyone to touch me, anyone to see me, because, as I was already part of this system I knew how much insensitivity there was, how much irresponsibility and disillusionment, and so no... I didn’t have any check ups at all. My body was telling me, nature was telling me, my instinct was telling me that everything would work out ok, because the baby continued to move, I was eating well.”

At eight months pregnant, Ruro left her studies in Cusco and travelled to Lima to look for Angela Bocker¹³⁷, a German doctor specialising in natural childbirth, recommended to her by a friend and former patient. Angela agreed to care for Ruro and she described the experience of giving birth at the clinic as being “magnificent”.

¹³⁷ Angela Bocker set up *Pakarii* (meaning “to come out into the light/begin something new/be born”), a delivery clinic in April 1995. *Pakarii* aims to promote and spread the philosophy of natural childbirth at all stages of pregnancy. The Organisation provides research and training opportunities for doctors, obstetricians, psychologists, therapists and doulas and assists in delivery and birth. See www.pakarii.com for further information on Pakarii’s work.

From this moment on, Ruro says that she was “absolutely convinced” that she wanted to work in the field of natural childbirth and so she returned to Cusco to finish her obstetric training. Ruro began working as an obstetrician in the Lorena Hospital in Cusco, which she describes as something that made her “very sad” seeing the way that childbirth was managed there:

“Nobody ... I didn’t know a single obstetrician or doctor who had (training in) humanised childbirth. I made a great effort to ensure that (my patients) breathed properly, that they relaxed, to give them their *aguaita* (herbal infusion), and a lot of the time I would make this huge effort to apply the technique and meanwhile (the obstetricians) would shout at them, they would slap them ... so you see they just weren’t interested in the technique. I didn’t ask them to try it, I just ended up doing it all myself. I loved assisting deliveries by myself because a woman’s privacy is fundamental when she is giving birth. Her hormones work better. And birth is of course such a private act too. So when it was just the two of us, everything used to work out better”.

Applying the principles of natural childbirth that she had learnt from Angela Brocker she began to run antenatal classes and the group of pregnant women attending grew quickly from 2 initially to 28. Realising there was demand from the women for this humanised approach to childbirth¹³⁸ Ruro began to work as a Doula accompanying women to the clinic to give birth whilst simultaneously promoting the principles of humanised childbirth amongst her work colleagues. In 2010, Ruro, along with several of her obstetric work colleagues, opened the doors of the *Casa de Nacimiento*, run from within her home in Cusco.

Officially registered as a private establishment offering antenatal care and advice to pregnant women, her clientele are mixed, made up of some wealthier upper class Cusquenian women, although the majority of her clientele are indigenous women seeking an alternative to clinically managed birth. Owing to the impoverished socio-economic status of many of her rural clientele, Ruro does not charge a fixed amount for her services and instead accepts agricultural produce such as quinoa or corn in lieu of monetary payment. Aware that giving birth in her home can bring bureaucratic complications for her patients as they try to register their child (see previous section),

¹³⁸ See Davis-Floyd (2001) and Davis-Floyd et al., (2009) for a discussion on the components of the humanised birth model.

she relies on a friend who works in a peripheral health establishment on the outskirts of Cusco province to furnish her with the necessary birth certificates. Also aware that by allowing women to give birth inside her home she is operating at the margins of the law, Ruro defends her work as such:

“According to the law birth has to be clinically managed. So, what I say to myself is this, if anyone finds out, then it will be the woman (who has given birth in her home) who will defend me, you know? “It’s my right to give birth at home. It’s my right to give birth with who I want and where I want” and because of this I have asked them to support me. Also, as a health professional, I also say no (to *parto institucional*). They say that if a skilled health professional goes to the house of a woman giving birth, it also technically counts as a clinically managed birth. So then, this house is for women who don’t have a house...in - let’s say - comfortable conditions...clean conditions suitable to give birth in. In these cases that we have it’s as if I were lending them my house for a few days. It’s their house and it’s also my house”

Inside her house, the atmosphere is calm and welcoming and resembles a family home rather than a clinic: the ground floor houses a living room which serves as a reception area with a large, firm leather chaise longue upon which Ruro carries out examinations. There is a room equipped for antenatal classes (Figure 28), a delivery suite with birthing pool and a second room set up to offer *parto vertical*, which also doubles as a large bedroom, with a comfortable double bed where the new mother can rest in privacy with her partner and her baby if she wishes after having given birth. There is also a modern kitchen stocked with all the necessary herbs and plants to prepare the variety of teas that form an important part of the birth process in the Andes.



Figure 28: Antenatal room and classes in Ruro’s *Casa de Nacimiento*

Ruro attributes the success of her clinic directly to the Andean women who have rejected the obligatory obstetric clinic based birth imposed on them by the Ministry of Health and who form her main clientele:

“In reality, *parto vertical* is the position of choice for a woman, in which she feels most comfortable and safest. This position originated here in the Andes, around the area of Cusco. Those who believe in making rules, like WHO, have written that this birthing position should be employed, but the rules aren’t respected. As a result I am extremely grateful to those women who have resisted and I respect them. They have chosen to take the stance of “I prefer to die, staying at home and giving birth there”. Thanks to them perhaps someone saw what was going on and said “yes, something needs to change: let (the health professionals) go to them, let them stay at home and the health personnel go to them without altering their customs drastically or what they wanted”. Basically, women did not want to go to the hospital because they lay them down, invading their privacy, because Andean women are very private in this respect. Imagine then, how could you be expected to give birth when your hormones are increased 100% with oxytocin. Women need to give birth in a calm state, in a warm and loving environment, so it becomes very difficult, you know? And often things went as far as slapping the women, they have been given episiotomies even after they have given birth and they weren’t torn, only to adhere to a useless rule. So these women have really resisted and have said, “No, I am going to die at home” - and in fact, many of them did, - “but I am going to stand in opposition and give birth how I want to because that is what my body wants”. So, you can say that this is one of their customs you know, but *parto vertical* is not just a custom.... studies have shown that it facilitates childbirth a lot and it is the position that women need (to give birth).”

Ruro’s statement again raises important issues about how intercultural health is provided to Andean women. Her position as a trained MINSA obstetrician and simultaneously a *partera profesional* managing her own birthing centre, which places the cultural needs of Andean women centre stage, allow her greater insight into the tensions inherent in maternal health provision today. Like the Ministry of Health, she recognises *parto vertical* as being the option of choice for Andean women, however Ruro acknowledges that the possibility of giving birth in this way is not always offered to them despite the rhetoric underpinning the Interculturality in Health initiative which seeks to promote *parto vertical* as the cornerstone of culturally adapted maternal health provision across rural health establishments (MINSA, 2006) as I have shown in my literature review. Enrique, the director of CLAS Anta, who has

many years experience of delivering babies using *Parto Vertical*¹³⁹, and who also trains other Obstetricians in the delivery technique, also acknowledged this point:

“There are a lot of my female colleagues who don’t agree with (*parto vertical*). There are lots of them who learned to attend to a birth on a horizontal stretcher and they think that is the way it is. In the beginning I also thought like that, but seeing it from another point of view, you begin to change”.

Further, for Ruro, the quality of care women receive at the clinic is another major deciding factor influencing their decision to disregard obstetric birth practices: Ruro cites examples of unnecessary surgical procedures; mistreatment of the patient during labour; and lack of privacy. Significantly, Ruro views the women’s rejection of current MINSA maternal health practices as resistance, but underlines that this resistance is *not* based around cultural traditions and customs but rather is founded in the knowledge that *parto vertical* is the most appropriate position to facilitate childbirth, a viewpoint Enrique also agreed with:

“We know that *parto vertical* ... is more natural, is more... it has more heritage. It is about knowing how to manage your own body. It is much, much more convenient for (pregnant women)”.

Ruro’s story also highlights important and on-going sea changes in how MINSA trained obstetricians are beginning to reinterpret maternal health provision. Although small scale and only accessible to a handful of rural women within easy reach of Cusco, Ruro’s *casa de partos*, is nevertheless the result of a concerted effort made by MINSA trained obstetricians to address not only the cultural challenges exposed by shortcomings in state run health establishments, but also to recognise the rights of rural women to be allowed to give birth where, when and with whom they wish. The *casa de partos* therefore not only stands as testament to the resistance of rural women, but also to the resistance of health professionals to actively reject state imposed directives on Andean women’s reproductive and maternal health. Yesica’s story, recounted below, offers a dual perspective on resistance to *parto institucional*, as Yesica is simultaneously a health professional working for MINSA *and* a pregnant *chiarina* who opts to give birth at home.

¹³⁹ Prior to working at the clinic in Anta, Enrique worked for some years in Belen Pampa, a MINSA run maternity clinic in Cusco, which currently specializes in *Parto Vertical*.

Yesica's story

When I arrived in Chiara in 2010 to begin my field research, there was only one nurse, Ines, present at the *Posta de Salud*. Ines told me that her work colleague Yesica was in Andahuaylas. When the village *combi* (minibus) trundled to a stop outside the *Posta* a few days later, Yesica could be seen inside dressed in her nurses' uniform, collecting together her belongings ready to disembark. Ines whispered to me

“She's pregnant. If you congratulate her she'll be really pleased, even though she hasn't officially told anyone. Say something to her later, in the *Posta*”.

I introduced myself to Yesica and duly waited until we were alone in the *Posta* later that afternoon to congratulate her on her first pregnancy. Yesica smiled shyly, thanked me and asked me to keep the news to myself. She did not ask how I knew she was pregnant, although it would soon be impossible for her to keep her pregnancy a secret much longer: her pregnancy was beginning to show beneath her nurses' uniform.

At the same time as Yesica's pregnancy was becoming apparent, unknown to us all in the *Posta* at the time, Rosalinda, who lived uphill a short distance from the health post, was also recently pregnant. As I have documented in Chapter 4, Rosalinda did everything possible to hide her pregnancy until she was 35 weeks, whereupon, tipped off by the ACS, (Community Health Agent)¹⁴⁰ Juan Antonio, the obstetrician, visited her at home and confirmed her pregnancy. The discovery of Rosalinda's pregnancy unleashed a series of monitoring strategies, meetings and openly hostile confrontations between practitioners, Rosalinda, her family and the village authorities, discussed in Chapter 4. Yesica was present at several of these meetings between Victor, Rosalinda's husband and the *Posta* staff. She did not hold back in giving her opinion of Rosalinda, declaring her to be “irresponsible” for not informing the *Posta* staff that she was pregnant; “stubborn” for failing to attend her antenatal checks, and “ignorant” for refusing to agree to give birth in the clinic in Huancaray. On one occasion, I witnessed Yesica become embroiled in a heated verbal argument with Rosalinda and her husband, claiming that she had witnessed Rosalinda give birth in the street outside the *Posta* at the end of her last pregnancy, and that it was she who

¹⁴⁰ See chapter 3 for a discussion of the role of the ACS.

had had to help Rosalinda into the clinic and then “clean up the mess” in the main street.

Whilst Rosalinda’s pregnancy, hidden for so long beneath her wide *pollera* (traditional pleated skirt) thus attracted an enormous amount of attention in the village once it came to light, Yesica’s pregnancy, now highly visible beneath her nurses’ uniform did not. She carried on working at the clinic as usual, and as part of her duties as the nurse charged with administering the *Juntos* programme (Chapter 3), continued to monitor the women enrolled in the programme and inform the regional coordinator of any non-compliance on their part. Unlike Rosalinda, who became a focal point for village gossip, Yesica’s pregnancy was not discussed amongst the women in the village, and indeed was rarely commented on in the *Posta* itself.

Perhaps it was because of these factors, - her everyday presence in the clinic, her nurses’ uniform bestowing her with a position of authority, her active role in monitoring the other pregnant women in the village, and her outspoken criticism of Rosalinda – that for a long time I failed to notice that no one was in fact checking up on Yesica and the progress of *her* pregnancy. As a pregnant woman in Chiara, she should have been attending antenatal checks with Juan Antonio, the obstetrician. She would, like all other pregnant women in the village, be required to attend the *Casa Materna* in Huancaray and give birth in the clinic there in due course. One afternoon, taking advantage of a quiet moment during her CRED clinic (*Crecimiento y Desarrollo*: Growth and Development) for the Under 5’s in the village – a requirement of the *Juntos* programme – I broached the subject with her. Asking her if she was having antenatal checks at the clinic she replied,

“Do you think I am going to let that doctor anywhere near me?”

Yesica was referring to Doctor Jeanette, the young doctor from Lima completing her SERUMS (rural service: as discussed in Chapter 6) in Chiara. I knew that the professional relationship between Yesica and the doctor was strained; Yesica had complained to me on several occasions that she was fed up of being the “bad nurse”: at Doctor Jeanette’s insistence Yesica was charged with monitoring the patients and informing on them if they did not adhere to the rules of the *Juntos* programme. Yesica

said she was attending antenatal appointments in Andahuaylas¹⁴¹. She did not elaborate and I understood the conversation to be closed.

Some weeks later I suffered a road traffic accident when the village *combi* (mini bus) swerved off the mountain road. Injured, I returned to Cusco for three weeks to recuperate and when I returned to Chiara, Yesica had given birth to her baby. If her pregnancy had gone largely uncommented upon, the birth of her child had not. I soon began to overhear snippets of conversation between village women, gossiping about the events surrounding her delivery. One of the women with whom I had become friendly filled me in on the details:

“She gave birth at home, you know? Of course we aren’t allowed to, (*imitating doctor*) “oh no, *Señora* (Madam), it’s the clinic for you”, but she did, all right. She denies she meant to but she did, because we heard her screaming in pain all afternoon. She says she called an ambulance, but the ambulance got there too late because the baby came out so quickly. But it’s not true. We know, because we all heard her shouting all afternoon. She got the Governor (her husband) to call the ambulance once the baby was out, and then they just pretended it was too late. That’s when she went to the clinic, when it was all over. And of course they didn’t get fined, they all know her because she’s a nurse, *and* he’s the governor, so of course not”.

When I congratulated Yesica on the birth of her baby, she confirmed that she had asked her husband to call for the ambulance as soon as she went into labour, but the ambulance took “too long” to get there as it was not immediately available for dispatch to Chiara, some two and a half hours from the clinic in Huancaray. Further, because Yesica’s husband had called for the ambulance, which failed to arrive in time, she told me that she was not fined for giving birth at home, a regular occurrence for *chiarinas* who choose to forego institutional birth.

Yesica did not say anything further about the circumstances surrounding her home birth. However, in later personal communication with another member of the *Posta* staff, I learnt that despite Yesica attending her antenatal care in Andahuaylas drawing on the health insurance available to her as a nurse, nevertheless the expectation had been that Yesica *ought* to have given birth in the clinic in Huancaray like all

¹⁴¹ Some MINSA employed health professionals, depending on the terms and conditions of their contract with the Ministry of Health are covered by an in service health policy allowing them to access healthcare in specific state run clinics known as EsSALUD. Yesica’s nearest EsSALUD clinic was

chiarinas. However, it subsequently came to light after she had given birth, that unknown to the other *Posta* staff at the time, Yesica had previously arranged with several of the obstetricians working at the delivery clinic in Huancaray to attend to her birth from her home in Chiara.

Yesica's pregnancy and home birth bring to light important contradictions over the way in which maternal health policy is applied in Chiara. Whilst rural women are regularly surveilled, must attend regular antenatal appointments in Chiara, and are made to agree to a clinically managed birth in Huancaray, Yesica, by virtue of her position as the *Posta* nurse was able to travel to Andahuaylas, the regional capital, for her antenatal care. Further, using her contacts with work colleagues, she was able to persuade the obstetricians to travel to her home and assist her in delivering there, thus avoiding the stay in the *Casa Materna* in Huancaray as all *chiarinas* are required to do. In this way, she was also able to avoid a clinically managed birth, remaining at home when she went into labour and – as the women suggested – only calling for an ambulance when her baby had been born.

Yesica's home birth also unpacks an important point made by Ruro in the above section. Ruro noted that in attending to women from her home (the *Casa de Nacimientos*) in Cusco, she is operating at the margins of the law, given the prohibition of home birth in rural areas of the Andes. The women she attends are nevertheless receiving care provided by a Skilled Birth Attendant, in line with the requirements of MDG5, given her status as a former MINSA trained obstetrician. However, Ruro's work is not officially recognised because it is carried out outside of an officially sanctioned clinical space. Likewise, whilst she gives birth at home, Yesica, in calling for assistance from her work colleagues – practicing MINSA employed obstetricians – also receives the services of SBAs at birth. Nevertheless, the obstetricians must attend to Yesica clandestinely as they are also prohibited from attending to births outside of a clinically managed environment. Thus, the obstetricians must hide their work in this instance from their employer. Yesica's situation thus exposes contradictions in MINSA health policy: not only is the work of the community *partera* and the *partera profesional* unrecognised, in situations where home birth occurs and is attended by a MINSA trained obstetrician, the Ministry does

located in Andahuaylas (Chapter 6 discusses the different terms and conditions of employment for MINSA staff).

not recognise the work of its own employees. In such circumstances, obstetricians are obligated to work clandestinely to avoid state sanctions and reprisals.

However, Yesica's situation is unique (and somewhat ironic) in that she can only access this delivery option by drawing upon her contacts in the Ministry of Health, the very institution that subsequently fails to recognise her home birth as a legitimate delivery. Further, attendance at home by an SBA during birth is a virtual impossibility for other *chiarina* women who cannot draw on personal contacts within the Ministry of Health to sidestep *parto institucional*. They must, like Ruro's patients in Cusco, rely on the emerging *casa de partos* and the services of the *partera profesional*, of which none currently exist in the vicinity of Chiara, or give birth at home with the community *partera* in attendance. As noted above (and discussed in Chapters 3 and 4), home births incur fines and sanctions for *chiarina* women and health professionals alike.

Ruro and Yesica however, are both able to harness their contacts *within* MINSA to protect them from the fines and sanctions imposed for home birth by the same institution. Ruro calls upon a former colleague in a distant health outpost to furnish her with certificates confirming that her patient gave birth in a clinically managed environment; Yesica's husband calls her work colleagues in Huancaray to dispatch an ambulance claiming that his wife is in labour, omitting to mention that she has already given birth with the assistance of MINSA's own obstetricians. In this way both Yesica and the obstetricians who attended to her avoid sanctions. Had the ambulance not been called, the health authorities could have doubly sanctioned Yesica: as a pregnant patient choosing to give birth at home and also as a health professional disregarding the directives of MINSA's *parto institucional* maternal health policy, directives that she is employed to uphold.

Yesica's status as both a health professional *and* a patient afford a dual perspective on her decision to opt for a home birth. Aside from the contradictions of medical practice at play owing to her status as a health professional, Yesica's home birth illustrates how difficult it is to make assumptions about culture and raises important questions about how the Ministry of Health attends to such challenges. If we cast aside for one moment Yesica's profession as the *Posta* nurse, and look beyond her role monitoring the *Juntos* programme, Yesica is recast as a young woman of childbearing age, who,

like her neighbours was born and raised in Chiara. Contrary to what her position as *Posta* nurse dictates, as a pregnant *chiarina*, Yesica finds the constraints of maternal health policy as it is practiced on the ground in Chiara challenging. Like her neighbours, outside of her working hours, she lives a rural lifestyle dependent on subsistence agriculture and livestock rearing for the majority of her food supplies. In addition, her responsibilities as a *Posta* nurse make it difficult to travel to Huancaray to stay in the *Casa Materna* two weeks prior to giving birth. Strained professional relationships with work colleagues discourage Yesica from attending to her antenatal care in Chiara. Thus, understood from the perspective of a *chiarina*, Yesica opts for a home birth with her husband present; until 2009 a regular event in the village until clinically managed birth became obligatory for *chiarina* women. Whilst her professional status protects her from the monitoring and surveillance in place for other *chiarinas*, it is her status as a fellow member of the *chiarina* community that influences her decision to give birth at home. Having given birth as she wishes, she then harnesses the very system she has avoided to ‘protect’ her. Following health protocols imposed on *chiarinas*, her husband calls for an ambulance and the new family leave for the clinic. In this way, she ‘falls back into line’, a compliant *chiarina* patient once more.

Conclusion

This chapter has shown that despite the current prohibition of *parto domiciliario* (home birth) across rural areas of the Andes, Andean women continue to demand the right to give birth at home. In so doing they expose shortfalls in MINSA’s Interculturality in Health policy, designed and implemented to encourage rural women to set aside their preference for home birth and agree to a *parto institucional*. Home birth occurs outside of clinical spaces, and thus outside of state purview, where the Interculturality initiative and the monitoring and surveillance strategies employed to regulate rural women’s maternity cannot reach. The Ministry of Health therefore regards home birth as a continued cultural challenge (MINSA, 2010; Zafra-Tanaka et al., 2015).

In opting for a home birth rural women employ the services of a community *partera* or midwife. The *partera* fulfills an important biosocial function for indigenous

women (Murray de López, 2016), and is recognised as being in touch with the maternal health needs of the indigenous population (van Dijk et al., 2013). Her work involves many Andean birth practices and *post partum* care carried out in the privacy of the home over several weeks. The massages and bindings, which form the backbone of her *post partum* work continue to be regarded as essential by rural women, nevertheless such practices are missing from the state's intercultural care programme.

The omission of the *partera*'s work from intercultural health initiatives reflects her current illegal and unrecognised status in Peru. Once viewed as an important nexus between obstetric practice and rural populations (see MSPAS, 2009; Farmer, 2008; PAHO, 2017), the Peruvian *partera* was an interstitial figure, trained by the state and working in partnership with obstetricians to facilitate access to maternal health provision. Stripped of her status in 2009, when Peru moved to obligatory clinically managed birth (MINSA, 2009a; 2009b) the *partera* now works clandestinely, outside of state purview. The Ministry of Health currently views her work not as an asset to intercultural maternity care, but rather as an obstacle to it. The biggest challenge for the *partera* thus lies in the refusal of the state and medical institutions to see her as an equal partner in the provision of quality reproductive and maternal healthcare.

The prohibition of the *partera*'s work means that she cannot legally register a birth. This has consequences for Andean women who choose her services. Despite opting to forego a clinically managed birth in a state run establishment, the *partera*'s patients must nevertheless engage with the state by attending a clinic to obtain the necessary paperwork to allow them to register their child's birth. Andean women giving birth at home are thus obligated to employ mixed economies of care in order to register their child as a Peruvian citizen. In excluding the *partera* from intercultural healthcare initiatives, and simultaneously empowering state run health establishments as the *only* means to register their baby's birth, the state obligates Andean women to negotiate their way through the competing discourses emanating from the cultural and the institutional.

Disconnects between the cultural and the institutional also surface in the recent emergence of the *casa de partos* (birthing house) in Peru. Combining Andean birthing practices and *post partum* care with modern obstetrics, the bespoke service provided

to rural women by the *partera profesional* offers an important, albeit small-scale alternative to state run *parto institucional*, one which engages successfully with the cultural, the institutional and the lay practices associated with childbirth in the Andes. The emergence of the *Casa de Nacimientos* highlights the active resistance to state run maternal care not only by Andean women who form its principal clientele, but also from a growing number of professionally trained obstetricians. However, unlike her MINSA employed counterparts, the obstetrician turned *partera profesional* works clandestinely, unable to legally register births taking place at the *Casa de Nacimientos*, despite her professional obstetric training.

Yesica's story synthesises the growing resistance to state run clinically managed birth in the Andes: she is both a MINSA employed health professional *and* a pregnant *chiarina*. Her dual status exposes the contradictions at play in medical practice and further highlights the tensions for Andean women when the institutional and the cultural collide. As a rural *chiarina*, Yesica wishes to give birth at home, like her neighbour Rosalinda. Unlike Rosalinda, because of her status as a health professional, Yesica is able to draw upon her professional contacts to allow her to sidestep *parto institucional* (clinically managed birth): her work colleagues, obstetricians employed by MINSA, agree to attend her delivery in her own home. However, they must do so clandestinely, as the birth takes place outside of a designated state run birthing clinic. Having circumvented the undesired aspects of the public health system (Unnithan-Kumar, 2001), Yesica reengages with the system in calling an ambulance to take her to the clinic, as all *chiarinas* must do. Her status as a health professional *and* pregnant rural woman allows her to simultaneously circumvent the system and also harness it to protect both herself and her work colleagues from sanctions and fines; an impossibility for other *chiarinas* like Rosalinda. Contradictions in medical practice aside, Yesica's home birth illustrates how difficult it is to make assumptions about culture and raises important questions about how the Ministry of Health attends to such challenges. As I have shown in this chapter, rural Andean women, *parteras*, *and* health professionals have begun to actively resist state imposed directives obligating clinically managed delivery despite the state's promotion of intercultural maternal care. I argue that the most significant form of resistance to maternal health practices emanates from the state itself, which continues to position the community *partera* as a 'cultural barrier' to improved MMR. In refusing to acknowledge the important socio-

cultural function that the *partera* fulfils, in rejecting her practices and the increasingly important work of the *Casa de Nacimientos*, the state obligates Andean women searching for alternatives to *parto institucional* and the midwives charged with their care, to deliver outside of state purview and at the margins of the law.

Chapter Eight: Conclusion – Disentangling the ‘cultural’ from Maternal Health

Introduction

“The cultural and the traditional are much more prevalent than modern medicine when it comes to maternal health. First, they (rural women) will opt for the traditional, the natural, to treat themselves. Medicine comes second. We are the second option: even now”

(Janeth, obstetrician in Izcuchaca: 2011)

This thesis has focused upon the institutional and cultural constructions of what it means to become a mother in present day Andean Peru. I have documented how, with maternal mortality ratios almost twice as high in Andean regions of Peru (MINSA, 2010), indigenous women living in the Andes have become the focus of targeted maternal health programmes. Peru’s Ministry of Health has promoted a policy of *parto institucional* (clinically managed birth) in an attempt to lower the maternal mortality ratio (MMR) in the Sierra, reacting to Andean women’s historic preference for home birth. In so doing, the Ministry of Health has introduced a series of intercultural health initiatives, designed to encourage Andean women to deliver in designated health clinics. Obstetricians are instructed to respect women’s cultural preferences, offering *parto vertical* (vertical delivery) birthing techniques, whilst at the same time, the work of the community *partera* (midwife) has been marginalised by the state. Cultural assumptions built around traditional preferences for home births have thus influenced policy measures, significantly impacting on the maternal health choices available to rural women. To ensure a *parto institucional*, women living in isolated, geographically ‘hard to reach’ populations must stay in a *Casa Materna* (maternal house) located next to the clinic, until their labour begins. Cash conditionality programmes such as *Juntos*, - rewarding women with a cash allowance in exchange for their adherence to maternal health policy – are used to encourage their participation. Peru’s Ministry of Health has turned maternity into a particular type of cultural problem, underpinned by ethnicity, impoverished socio-economic status, low educational level and isolated rural location (MINSA, 2010). However, if we want to engage fully with the issues shaping maternal health across the Andes

region, as I have shown in this thesis, we must first understand the wider issues influencing rural women's maternal health choices, decisions and practices.

Throughout this thesis I have challenged the assumptions about culture underpinning the Ministry of Health's current maternal health policy, by examining the practices and understandings of the social actors involved in maternal health. I began by ethnographically examining the maternal health encounter where pregnancies are confirmed and decisions regarding birth choices are made. Paying close attention to the lived experiences of both rural women and their families accessing maternal care, and those of the health professionals charged with providing their care, I have revealed the disjunctures occurring between policy understandings and practices as they are lived out across rural terrains. Situating maternal health interventions within the context of the everyday has also exposed the biopolitical arrangements that shape women's maternity. As I have shown, culture is mobilised to ensure that rural women – and the practitioners charged with their care – conform to social and institutional expectations. This thesis has shown that in order to fully understand Peru's maternal health 'problem' then, we must situate it within the local contexts and lived experiences in which it is firmly embedded. MMR and maternal health outcomes must be understood from within the socio-economic, political, institutional or familial contexts and embodied experiences within which birth takes place.

As a consequence, it is therefore insufficient to understand the 'maternal health encounter' as simply a series of antenatal consultations taking place within a local *Posta de Salud* (health outpost), a period of time spent at the *Casa Materna* (maternal house), or a clinically managed birth in a designated delivery clinic or hospital. To do so would be to examine only one aspect of maternal health provision, therefore necessarily limiting our understanding of the phenomenon. For Andean women, maternal health encounters happen everyday, across different sites and with different people. It is not just the obstetrician, doctor or *Posta* nurse who guides, informs and influences their reproductive trajectories. As I repeatedly witnessed during my fieldwork, thoughts, perceptions, opinions and experiences related to pregnancy and birth are voiced, commented upon and discussed with family, friends, and neighbours whilst travelling on overcrowded *combis* (minibuses) en route to market, when shopping, cleaning or cooking, tending to livestock or sowing and harvesting in the

chacra – the familial plot of land. It is here, in these diverse everyday settings, in conversation with different people, that rural women take their decisions and make their choices pertaining to their maternity. Thus, to gain a richer understanding of what is considered important to them, this study has also included maternal health encounters occurring outside of clinical spaces. In the intimacy and routine of everyday home life, we learn what really matters for Andean mothers today. This thesis has therefore explored the interplay between lived experience, the disjunctures and the commonalities in modern obstetric approaches to pregnancy and childbirth, and the understandings, practices and lay knowledge associated with lay midwifery. I discuss these findings in more detail below, using a narrative extract from an interview with Elena, a rural *chiarina* and mother of two, to assist me in drawing out the various facets of maternal health experiences that I have explored during my research.

Rural women's experiences and perspectives of maternal health encounters

“They wanted to send me to Huancaray, so I said to them “After the *fiesta* (celebrations), then I will go”. I said that but I didn’t want to go. Then I went into labour, during the celebrations. In the afternoon I said to my mum, “Mum, my belly is hurting”. “You are going to give birth” she said. The pain was growing more and more. At 11pm I told my husband, when the pain was worse. “My belly is hurting”, I told him. My husband came home, he was at the village *fiesta*, everyone was there. My in-laws came home too. My husband went to the *Posta* to tell them. “If you are going to give birth in your house they will fine you”, everybody had told me. So my husband went to tell them. There was nobody in the *Posta*, Maria. The *Posta* was closed. They were in their rooms sleeping it off after the party. So what can I do? Am I going to let a drunk attend to me? It was getting light. I gave birth at eleven in the morning, but here in my house. The next day my husband went to tell the nurse. “My wife has given birth at home. You didn’t help her”, he said. “I came to tell you and you were drunk”. So after that they didn’t do anything. “ok *mamacita*¹⁴², you won’t have to pay the fine”. They left it there”.

(Elena, rural mother, Chiara: 2010).

¹⁴² *Mamacita* (literally ‘little mum’) is a slang term of address used commonly in the Andahuaylas and Cusco regions of the Andes. In its more common form *mama*, it is regarded as a respectful term of address used by Andean women to address each other. In its diminutive form cited here, it can be construed as either affectionate or disrespectful, depending on circumstance and the social position of

The narrative cited above is an extract from one of my many conversations with Elena, whom we first met in Chapter 3 of this thesis. She is describing the birth of her eldest daughter, in 2000. Her narrative serves here to frame exactly what is important to rural women when managing their maternity, as I have discussed throughout this thesis. Elena's narrative emphasises rural women's perspectives and experiences of birth in the Andes as practiced under the constraints of current maternal health policy, highlighting the disjuncture between what is supposed to happen and what happens in reality when policy measures are implemented in local contexts. In the remainder of this chapter, I will use her narrative to draw together the key contributions of this thesis.

"If you are going to give birth in your house they will fine you"

Elena refers to the need to go to the *Posta* to give birth, warned by her fellow *chiarinos* that her failure to do so will result in her being fined for giving birth at home. As I showed in Chapter 3, the 'shadow conditionalities' (Cookson, 2016) – the unofficial conditions attached to enrolment - implicit in the cash transfer programme *Juntos*, require that pregnant women regularly attend antenatal appointments and give birth in designated health establishments. When pregnant women choose not to conform to expectations their actions unleash a series of coercive measures and controlling mechanisms designed to moderate their wayward behaviour. Andean women are regularly monitored, surveilled and pressured to conform to policy dictates. Women who refuse to conform to expected behaviours are publically berated, shamed and instructed upon how to become a 'good' mother: following the 'rules', attending antenatal appointments regularly, giving birth in a clinic and bringing their new-born to the *Posta* for CRED: growth and development monitoring appointments. 'Bad' mothers are removed from the social development programme *Juntos*, effectively cutting their only source of cash income. In contrast, 'good' mothers, those that abide by the 'rules', are rewarded with economic incentives and held up in public health *charlas* (talks) as shining examples of motherhood to follow. The *Juntos* programme requires that practitioners actively engage in the monitoring of their patients' behaviour, reporting non-compliance to the rules to programme

the people involved in the conversation. It is unclear whether *mamacita* was used here to denote disrespect or affection from one *chiarina* to another.

coordinators. In this way, practitioners effectively become positioned as ‘agents of the state’, charged with enforcing government directives leading to tensions and disagreements amongst themselves and the patients they care for.

However, governmental monitoring and surveillance, as I have noted, is not limited to the surveillance of rural women, it also includes the professional practices of the obstetrician. Despite being agents of the state, their actions are also constrained. Where a patient fails to attend an antenatal consultation, or gives birth at home, practitioners’ work is *observado* (noted), and may trigger investigations led by DIRESA, the regional health authority, ultimately leading to the practitioner’s dismissal. In addition, practitioners are required to meticulously record every consultation and health encounter that takes place and send this information to DIRESA on a monthly basis. Failure to accurately record information, or where new registrations at the clinic fall below set targets, also generates reprimands from the regional health authority. Elena was excused from paying the fine for giving birth at home in this instance because the health professionals at the *Posta* knew that they would also be investigated for infringement of the rules: closing the *Posta* and attending the village *fiesta*¹⁴³. By not reporting her home birth, they also avoid investigation.

Responsibility to ensure compliance is shared amongst different social actors. Maternal health is understood to be a community wide responsibility. In the first instance health professionals must ensure that the *gestante* conforms to policy dictates. When this is not so (as we saw in Rosalinda and Milagros’s stories), members of Andean communities are assigned the moral responsibility of ensuring the *gestante* modifies her behaviour. As Elena explained in her narrative above, other *chiarinos* warn her that she must go to the clinic or risk being sanctioned. When a new mother or her family dare to question or disagree with the health professionals’ decisions, community authorities (such as the Police, Mayor, local President or Governor) are called upon to pressure the family to acquiesce. The ACS, the community health worker, whose role is ostensibly to ‘cross (cultural) boundaries’ (Vidal, 2015) between community and health professionals, is in practice employed in Chiara to surveil and monitor community women and their behaviours, informing

¹⁴³ It should be noted here that village *fiestas* Chiara traditionally last between 3 days and a week, depending upon the occasion.

health professionals at the *Posta de Salud* of any women that have come to her attention who may be pregnant.

“After the fiesta, then I will go”

In monitoring, sanctioning, and rewarding motherhood, maternal health becomes situated as ‘moral experience’ (Kleinman, 1999a; 1999b), as “certain things (come to) matter greatly, even desperately” (Kleinman, 1999a:360) for rural women. Elena states in her narrative above that she had already agreed to travel to the *Casa Materna* in Huancaray. However, she only agreed to do so after the important village celebrations were over. It matters for her that she attends, as do her family, and indeed as we have seen, it matters to the *Posta* staff too that they attend. In Chapter 4, I discussed maternal health as moral experience, discussing what really matters for rural women and their maternal health. Arthur Kleinman suggests that people’s actions are “characterised by an orientation of overwhelming practicality” (ibid). What is at stake for rural women in the Andes then are the pragmatic concerns of the everyday: who will care for their other children whilst they are in the *Casa Materna* in Huancaray far from home? Who will keep house, cook, clean and tend the livestock and crops? These are the important questions that Peru’s maternal health policy and intercultural initiatives fail to consider and much less address. Housework and child rearing is still very much a gendered activity in Peru, considered “motherwork” (Murray de López, 2016). Men often travel over long distances to find work, as we saw in the case of Rosalinda’s husband Victor, whose work as a musician took him away from home for extended periods of time. Men may also travel to other provinces of Peru, such as Violeta’s husband who worked in the mine in the neighbouring province of Madre de Dios. Faced with these challenging circumstances, finding themselves ‘home alone’, the impracticalities of health policies requiring that women travel long distances to stay for extended periods of time in *Casa Maternas* are obvious. ‘Motherwork’ (ibid) thus plays a large part in deciding where an Andean woman chooses to give birth, rather than assumed cultural preferences for *parto vertical* (vertical birth) and *parto domiciliario* (home birth) made by the Ministry of Health.

“My husband came home... my in-laws came too”.

Elena’s narrative highlights the centrality of the family at delivery. Learning that she is in labour, both her husband and his parents return home from the celebrations to accompany her. Chapter 5 discussed the importance of family members’ involvement during pregnancy and at birth, a factor recognised by the Ministry of Health on their Delivery Plans where pregnant women are asked to name the family members who will accompany them to the clinic and throughout their labour. However, as I have shown, the Ministry of Health, in involving family members, does so in order to ensure that they bring the *gestante* to the clinic to give birth, rather than a genuine concern to meet the needs of the labouring woman. The Ministry also assumes that family members are readily available to accompany women to distant clinics. Yet, when familial support is not forthcoming, due to work responsibilities as cited above, my research shows that women become vulnerable in clinically managed birth scenarios. Dispatched alone for an emergency caesarean in Cusco, Violeta finds herself vulnerable to mistreatment and verbal abuse from health staff. Without her family for emotional and moral support, she relies upon her ‘*hermanas*’ (sisters) – the other women on the ward – to meet her needs. Alone and vulnerable, she leaves the hospital unaware as to whether she has been sterilised as she requested after her emergency caesarean. Milagros, transferred alone to Lima for emergency obstetric care, keenly feels the absence of family around her, forcibly separated from her newborn son and her husband. The trauma of her separation later becomes embodied in ill health, which she understands as *sobrepardo*: illness occurring as a direct result of the difficulties and emotional trauma she experienced during childbirth. Her experiences impact significantly on her future fertility; Milagros seeks contraceptives from the *Posta* on her return to Chiara to avoid having to give birth again.

“They wanted to send me to Huancaray...I did not want to go”

Centro de Salud Huancaray, the delivery clinic where *chiarinas* must give birth, is located two and a half to three hours from Chiara by *combi*, the infrequent minibus service that departs from the village twice a day. To get there means health professionals must rely on minibus drivers to transport heavily pregnant women across challenging terrain. There are no ambulances in Chiara, and only one in CS Huancaray, often dispatched to neighbouring rural hamlets in emergencies. The roads

to and from Chiara are not made of tarmac; for the most part they are earth, sometimes topped with a sprinkling of small stones, known as *trocha* in the Andes. In rainy season, these twisting, torturous roads, weaving their way through the high altitudes of the Andes become virtually impassible. The journey is tiring and often dangerous. Road accidents are frequent. Elena does not want to go.

Elena's reluctance to travel, borne from the challenges imposed crossing rural terrains in often inclement weather and the difficulties in organising these journeys when public transport is severely limited, is one of the challenges that health professionals must regularly contend with. In Chapter 6 of this thesis I explored the impacts that geography and logistics had not only for rural women, but also on the work that health professionals must do to ensure their patients deliver in the designated *Centro de Salud*. I showed how the remoteness of their location, and the access difficulties associated with reaching them, have led rural women and their families to become designated as 'hard to reach' populations. Their geographical remoteness becomes redefined as a population trait, rather than a description of the difficulty service providers have in reaching them (Street, 2016). Labelled culturally and ethnically as 'problem populations' (Taylor, 2007), rather than simply populations with access difficulties, rural women then become the focus of targeted maternal health interventions. As a result, health professionals have been responsabilised to ensure that when a pregnant woman from a rural community does attend the clinic, she is rushed through a series of different consultations on the same day: her return at a later date cannot be guaranteed. Health professionals recognise that like Elena, many rural women do not wish to travel long distances over difficult terrain to fulfill their maternal health obligations to the state.

Further, these visits generate increased workloads for health professionals in ensuring the *gestante* receives the complete package of maternal health services to which she is entitled under the SIS insurance scheme. However, uninsured citizens are a common occurrence in the *comunidades campesinas* around Izcuchaca. By virtue of their being uninsured, these pregnant women remain unseen by the state. In the event that rural populations cannot reach the clinic, or choose not to come to the clinic, the clinic must therefore come to them. Accordingly, new health strategies require that health

personnel travel to remote communities to attend patients ‘in the field’. Campaigns to enroll new patients are a regular occurrence in Izcuchaca, generating an increased workload for health staff. The measures are controversial and not well received by all staff. Workplace tensions increase as contractual differences between *nombrados* – (staff on a permanent contract), and *contratados* (staff on a temporary or fixed term contract) are used to justify why certain doctors refuse to travel to remote locations to treat patients. The value and recognition of health professionals’ work is called into question as staff perceive that their work is largely invisible to the state, and yet at the same time they are required to render populations legible to the state apparatus by actively searching out and registering new patients.

“My wife has given birth at home. You didn’t help her”

When Elena’s husband goes to the *posta* to report that his wife has given birth at home, he emphasises that the *posta* staff were not available to help her because they had closed the health establishment to attend the celebrations taking place in the community. At the birth of Aida then, the health professionals failed to meet Elena’s needs. Unable to give birth in the clinic, she has no choice but to do so at home.

The failure of state provided maternal healthcare to adequately meet the needs of rural women was exemplified in Chapter 7 of my thesis, where I explored the mixed economies of care that rural women are obligated to negotiate. Women do not always make their maternal health decisions about where and how to give birth simply because of straightforward cultural preference, but rather, as Elena’s narrative has shown, the way the public health system operates curtails their choices. Withdrawing the legal status of the community *partera*’s work after 2009, the Peruvian state simultaneously marginalised her practices, thus curtailing the role of a key maternal health provider amongst rural women. In so doing, the Peruvian state fails to acknowledge the important biosocial aspects of the *partera*’s work with rural women (Murray de López, 2016). There are many practices related to birth and *post partum* care in particular - such as the bathing of the new mother in herbal infused baths and the *fajada* (binding) of her body, that are excluded from intercultural health initiatives across state run health establishments. Once regarded as an interstitial figure, trained by the state and working alongside obstetricians, the biggest challenge for the lay *partera* today lies in the state’s refusal to view her as an equal partner in intercultural

health initiatives. Precisely because her work is unrecognised, she cannot register a child's birth. This has important consequences for women who choose to forego state provided maternal health. Despite opting for a home birth, they must nevertheless access the state system to obtain the relevant paperwork issued in state health establishments which allows them to register their child as a Peruvian citizen. Andean women must therefore negotiate their way through the competing discourses emanating from the cultural and the institutional.

The bespoke service provided to rural women by the *partera profesional* offers an important, albeit small-scale alternative to state run *parto institucional*, one which engages successfully with the cultural, the institutional and the lay practices associated with childbirth in the Andes. However, like the lay *partera*, the obstetrician turned *partera profesional* works clandestinely, unable to legally register births taking place at the *Casa de Nacimientos*, despite her professional obstetric training.

Yesica's story, as both a pregnant *Posta* nurse and a *chiarina*, exposes the contradictions at play in medical practice and further highlights the tensions for Andean women when the institutional and the cultural collide. Yesica chooses to give birth at home, and harnesses her obstetric contacts within the Ministry of Health to do so. Having given birth she reengages with the formal state run health system, calling an ambulance to take her to Huancaray. Her status as a health professional *and* pregnant rural woman allows her to simultaneously circumvent the system and also harness it to protect both herself and her work colleagues from sanctions and fines; an impossibility for other *chiarinas* like Rosalinda as we have seen. Yesica's home birth illustrates how difficult it is to make assumptions about culture and raises important questions about how the Ministry of Health attends to such challenges.

Reconceptualising maternal health

In conclusion then, this research has shown that we cannot attend to continued high percentages of MMR across Andean regions by addressing the problem primarily as a cultural one. In this thesis I have challenged the assumed disjuncture between obstetric practice and Andean birthing practices harnessed by the Ministry of Health to account for the elevated ratios of maternal mortality in the Andes. Ethnographically examining the maternal health encounter, I have emphasised the perceptions and

experiences of rural women and the health professionals providing their maternal care. I have shown that maternal health as it is understood, negotiated and practiced in the Andes in 2018, is deeply influenced by the historical and political, institutional and familial, economic and biosocial structures into which it is embedded. The continued reification of 'Andean culture' evidenced in Ministry of Health policy documents, health strategies and programme initiatives from 2009 to the present, perpetuates the very disjuncture that the Ministry of Health seeks to dissolve via 'intercultural' healthcare initiatives across Andean regions.

I advocate that future policy makers and practitioners, in attending to health inequalities and disparities in areas with high MMR in the Andes, consider the challenges of the everyday faced by rural women. The successful design and implementation of future maternal health policies depends upon rural women being adequately consulted to determine their needs. Greater consideration must also be given to the very specific local contexts into which maternal health is embedded. Historical and political, institutional and familial, economic and biosocial influences impact upon women's maternal health decision-making as I have shown. Only then, when we have a true sense of 'what really matters' for rural women when managing their maternity, can we prevent the erroneous labelling of women as 'culturally difficult', and also begin to prevent their unnecessary death when labouring to bring forth new life.

Appendices

Appendix 1: List of Interview Topics

Patients and family members

Narrative interviews with patients and family members started with the following question:

- Can you tell me about your/your family member's experience of being pregnant/having a baby? Please begin at any point you wish.

If they needed prompting, I asked specific questions such as:

- Could you please tell me when you found out you were having a baby?
- How did you realise that you were having a baby?
- When did you decide you needed to see a doctor?
- What happened next?

Further interviews, either narrative, semi-structured or informal, focused on the following topics:

- a) The trajectory of the pregnancy and all associated treatments.
- b) Ante natal follow-up and tasks requested by the medical services.
- c) Strategies to obtain support (familial, economic, emotional).
- d) Problems faced throughout pregnancy and as a family.
- e) Patients' and families' perspectives on the pregnancy and birth.
- f) Everyday life and routines whilst pregnant.
- g) Ways of accommodating being pregnant at home (changes to routine and lifestyle).
- h) Ways of engagement with other expectant mothers and/or midwives.
- i) Family history and general information (number of members, employment, income).

Health professionals

Semi-structured interviews with health professionals based at community primary health outposts covered the following topics:

- a) Perspectives on the high incidence of MMR in the community/region.
- b) Medical services and support available for uninsured pregnant women at the primary health clinics (if any).
- c) Medical services available for the general population of the community.
- d) Guidelines or procedures to confirm pregnancy.
- e) Referral procedures and their relation to higher-level medical services (*Centros de Salud*: Health Centres) or hospitals.

Semi-structured interviews with health professionals based at public hospitals covered the following topics:

- a) Organisation of obstetric services available for pregnant women.
- b) Admission procedures for new/recently pregnant women.
- c) Forms of support available for uninsured pregnant women and their families (medical and financial, formal and informal), if any.
- d) Admission procedures to the clinic in cases of obstetric emergency.
- e) Post partum follow-up procedures.
- f) Collaboration with lay midwives.
- g) General views about MMR in Peru and in the Andes in particular.

Community/Lay and Professional Midwives (non-MINSA employed)

Semi-structured interviews with community/lay and professional midwives covered the following topics:

- a) The history of the *casa de nacimiento*.
- b) Their aims as an organisation.

- c) Forms of support offered to uninsured patients.
- d) Forms in which patients are asked to reciprocate for services provided (what is asked in return?).
- e) How the *casa de nacimiento* obtains its funding, medicines, and obstetric supplies.
- f) The challenges faced as a non-government funded *casa de nacimientos* that supports uninsured patients/patients choosing birth outside of clinical spaces.
- g) Collaboration with public hospitals, other *casa de nacimientos*/midwives and governmental institutions.
- i) General views about MMR in Peru and in the Andes in particular.

Community members

Semi-structured and informal interviews with community members covered the following topics:

- a) What everyday life is like in the community.
- b) What most people do for a living in the community.
- c) Whether a community member knows pregnant women from their community.
- d) Perspectives on the high incidence of MMR in the community/region.

Appendix 2: Sample of Participant Invitation Letter for Patients and Families



PhD Research Proposal

Maria-Anne Moore
June 2010

(Student no: 200726723)

On behalf of Maria – Anne Moore

Re: Invitation to participate in research - "Maternal Health and Reproductive Choice: a study of health encounters in the Peruvian Andes".

Dear *(insert name)*,

This is an invitation to participate in research being conducted by myself, Maria-Anne Moore, a PhD student in the Department of Public Health and Policy at the University of Liverpool.

The aim of this study is to explore maternal health experiences in *(name of village/town)*. Community members and healthcare practitioners are invited to participate to share and reflect on maternal health experiences.

We would like to invite you to take part in this study. Before you decide whether you wish to participate, it is important that you understand why the research is being done and what it will involve. Please find enclosed an information sheet that explains in more detail what the study involves and what your role in it will be if you choose to take part.

Please read this information carefully and ask me if there is anything that concerns you, that you do not understand, or if you would like more information.

Contact details

Maria – Anne Moore
Address in Peru: Villa el Periodista, G5, depto. 101
Wanchaq, Cusco, Peru.

Telephone: + 51 (0) 84 22 43 29

Email: mariacha@liv.ac.uk

· This was the working title of my thesis when I began my research. I subsequently changed the title after completing fieldwork and analysing the data to better reflect the research problem.

Appendix 3: Sample of Participant Information Sheet for Patients and Families



PhD Research Proposal

Maria-Anne Moore
June 2010

(Student no: 200726723)

On behalf of Maria – Anne Moore

Re: Invitation to participate in research - "Maternal Health and Reproductive Choice: a study of health encounters in the Peruvian Andes".

Participant information sheet

Who is doing the research?

Maria-Anne Moore (PhD student) Department of Public Health and Policy, at the University of Liverpool, UK.

Dr Ciara Kierans (PhD Supervisor) Department of Public Health and Policy, at the University of Liverpool, UK.

What is the purpose of the study?

The purpose of this study is to explore the maternal health experiences of women and their families living in (*insert name of village*). We are interested in understanding how maternal health impacts on the lives of patients and their families.

Why have I been chosen to take part?

You have been asked to take part in this study because you or your family member is pregnant or has recently had a baby. Your experiences are therefore very important to us.

Do I have to take part?

It is completely up to you. If you do decide you would like to participate, you will be asked to sign a consent form when you first meet the researcher. If you decide later on that you no longer wish to take part then you can leave the study at any time and do not have to give a reason.

· This was the working title of my thesis when I began my research. I subsequently changed the title after completing fieldwork and analysing the data to better reflect the research problem.

What will happen if I take part?

This research study will be asking for your involvement in two ways, depending upon what you feel comfortable with:

(1) In-depth interviews: You will be asked to take part in at least one interview and potentially a follow-up interview. You can choose to be interviewed on your own, or with your family/a friend present. The interviews will involve you talking about your experiences of being pregnant and having a baby or having a family member who has is pregnant or has recently had a baby. These interviews will last for approximately one hour or longer if you wish. With your permission, these interviews will be audio-recorded and then transcribed.

(2) Fieldwork and informal interviews: If you agree to it, the researcher may also spend some time with you to chat informally about your experiences and your life in general. From this he will take field notes.

Where will the research take place?

The research will be carried out at a time and place of your choice. You may like this to be your home or a public setting (e.g. in the town square or at the community meeting hall). It is up to you to decide.

Are there any disadvantages or risks in taking part?

We do not expect there to be any risks associated with participating in this research study. However, we realise that the topic is very sensitive, so if you feel uncomfortable or distressed at any time then you can stop the interview. You can also leave the study without having to give a reason.

Are there any benefits in taking part?

You will be helping with a new area of research. Your experiences will help us to better understand how being pregnant and having a baby affects the lives of patients and their families.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting the researcher, Maria–Anne Moore +51 (0) 84 22 43 (in Peru), or by email mariacha@liverpool.ac.uk, or her supervisor Dr. Ciara Kierans on +44 0151 794 5594 (in the UK) or by email ciarak@liverpool.ac.uk and they will try to help.

If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer, Sarah Fletcher, at the University of Liverpool on 0151 794 8290 or by email ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Will my participation be kept confidential?

All the information that you give us will be kept strictly confidential. The procedures for handling, processing, storing and destroying the data will comply with the Data Protection Act of 1998 of the UK. This means that only the researcher and her supervisor will see what you have said. All the information, which you provide us with during the study, will be stored in locked filing cabinets or password protected computers. Anything about you, including any quotes, which are used in the write-up of the study, will have your name removed and a different one put in place, so that you will remain anonymous. At the end of the study the research data (consent forms, anonymised interview transcripts, field notes, and your contact details) will be kept in locked filing cabinets and/or password protected university computers. The data will be kept for ten years, and then will be destroyed. What will happen with the results of the study? After the study has finished, the results will be put together as part of the researcher's PhD dissertation. The research will be stored at The University of Liverpool. The research will also be published in academic journals and presented at conferences.

What will happen if I want to stop taking part?

If you decide at any point that you no longer wish to be part of the study, then you can stop and do not have to give a reason for this. You can also ask for your data to be destroyed if you decide to stop being in the study.

Who can I contact if I have further questions?

Contact the researcher, Maria-Anne Moore: in Peru: Tel: + 51 (0) 84 22 43 Email: mariacha@liverpool.ac.uk or her Supervisor, Dr Ciara Kierans Tel: +44 0151 794 5594 (in the UK) Email: ciarak@liverpool.ac.uk

Appendix 4: Sample of Participant Invitation Letter for Health Professionals



PhD Research Proposal

Maria-Anne Moore
June 2010

(Student no: 200726723)

On behalf of Maria – Anne Moore

Re: Invitation to participate in research - "Maternal Health and Reproductive Choice: a study of health encounters in the Peruvian Andes".

Dear *(insert name)*,

This is an invitation to participate in research being conducted by myself, Maria–Anne Moore, a PhD student in the Department of Public Health and Policy at the University of Liverpool.

The aim of this study is to explore maternal health experiences in *(name of village/town)*. Community members and healthcare practitioners are invited to participate to share and reflect on maternal health experiences.

We would like to invite you to take part in this study. Before you decide whether you wish to participate, it is important that you understand why the research is being done and what it will involve. Please find enclosed an information sheet that explains in more detail what the study involves and what your role in it will be if you choose to take part.

Please read this information carefully and ask me if there is anything that concerns you, that you do not understand, or if you would like more information.

Contact details

Maria – Anne Moore
Address in Peru: Villa el Periodista, G5, depto. 101
Wanchaq, Cusco, Peru.

Telephone: + 51 (0) 84 22 43 29

Email: mariacha@liv.ac.uk

· This was the working title of my thesis when I began my research. I subsequently changed the title after completing fieldwork and analysing the data to better reflect the research problem.

Appendix 5: Sample of Participant Information Sheet for Health Professionals



PhD Research Proposal

Maria-Anne Moore (Student no: 200726723)
June 2010

On behalf of Maria – Anne Moore

Re: Invitation to participate in research - "Maternal Health and Reproductive Choice: a study of health encounters in the Peruvian Andes".

Participant information sheet

Who is doing the research?

Maria-Anne Moore (PhD student) Department of Public Health and Policy, at the University of Liverpool, UK.

Dr Ciara Kierans (PhD Supervisor) Department of Public Health and Policy, at the University of Liverpool, UK.

What is the purpose of the study?

The purpose of this study is to explore the maternal health experiences of women and their families living in (*insert name of village*). We are interested in understanding how maternal health impacts on the lives of patients and their families.

Why have I been chosen to take part?

You have been asked to take part in this study because you have particular expertise in maternal health. Your experiences are therefore very important to us.

Do I have to take part?

It is completely up to you. If you do decide you would like to participate, you will be asked to sign a consent form when you first meet the researcher. If you decide later on that you no longer wish to take part then you can leave the study at any time and do not have to give a reason.

· This was the working title of my thesis when I began my research. I subsequently changed the title after completing fieldwork and analysing the data to better reflect the research problem.

What will happen if I take part?

This research study will be asking for your involvement in two ways, depending upon what you feel comfortable with:

(1) In-depth interviews: You will be asked to take part in at least one interview and potentially a follow-up interview. You can choose to be interviewed on your own, or with your family/a friend present. The interviews will involve you talking about your experiences of being pregnant and having a baby or having a family member who has is pregnant or has recently had a baby. These interviews will last for approximately one hour or longer if you wish. With your permission, these interviews will be audio-recorded and then transcribed.

(2) Fieldwork and informal interviews: If you agree to it, the researcher may also spend some time with you to chat informally about your experiences and your life in general. From this he will take field notes.

Where will the research take place?

The research will be carried out at a time and place of your choice. You may like this to be your office or consultation room/surgery or a public setting (e.g. in the town square or at the community meeting hall). It is up to you to decide.

Are there any disadvantages or risks in taking part?

We do not expect there to be any risks associated with participating in this research study, however you can leave the study at any time without having to give a reason.

Are there any benefits in taking part?

You will be helping with a new area of research. Your experiences will help us to better understand how maternity and birth affects the lives of patients and their families.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting the researcher, Maria–Anne Moore +51 (0) 84 22 43 (in Peru), or by email mariacha@liverpool.ac.uk, or her supervisor Dr. Ciara Kierans on +44 0151 794 5594 (in the UK) or by email ciarak@liverpool.ac.uk and they will try to help.

If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer, Sarah Fletcher, at the University of Liverpool on 0151 794 8290 or by email ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Will my participation be kept confidential?

All the information that you give us will be kept strictly confidential. The procedures for handling, processing, storing and destroying the data will comply with the Data Protection Act of 1998 of the UK. This means that only the researcher and her supervisor will see what you have said. All the information, which you provide us with during the study, will be stored in locked filing cabinets or password protected computers. Anything about you, including any quotes, which are used in the write-up of the study, will have your name removed and a different one put in place, so that you will remain anonymous. At the end of the study the research data (consent forms, anonymised interview transcripts, field notes, and your contact details) will be kept in locked filing cabinets and/or password protected university computers. The data will be kept for ten years, and then will be destroyed. What will happen with the results of the study? After the study has finished, the results will be put together as part of the researcher's PhD dissertation. The research will be stored at The University of Liverpool. The research will also be published in academic journals and presented at conferences.

What will happen if I want to stop taking part?

If you decide at any point that you no longer wish to be part of the study, then you can stop and do not have to give a reason for this. You can also ask for your data to be destroyed if you decide to stop being in the study.

Who can I contact if I have further questions?

Contact the researcher, Maria-Anne Moore: in Peru: Tel: + 51 (0) 84 22 43 Email: mariacha@liverpool.ac.uk or her Supervisor, Dr Ciara Kierans Tel: +44 0151 794 5594 (in the UK) Email: ciarak@liverpool.ac.uk

Appendix 6: Sample of Consent Form



PhD Research Proposal

Maria-Anne Moore
June 2010

(Student no: 200726723)

On behalf of Maria – Anne Moore

Re: Invitation to participate in research - "Maternal Health and Reproductive Choice: a study of health encounters in the Peruvian Andes".

Participant Consent Form

1. I confirm that I have read and have understood the information sheet dated _____ for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected.
3. I understand that quotes from what I say during the study may be used where necessary, on the condition that my identity will remain anonymous.
4. I agree to being audio-recorded during the study interviews, on the condition that my identity will remain anonymous.
5. I understand that, under the Data Protection Act 1998 of the UK, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.
6. I agree to the research data being stored. I understand that the anonymised data (interview transcripts and notes) may be shared with other researchers in the future.

· This was the working title of my thesis when I began my research. I subsequently changed the title after completing fieldwork and analysing the data to better reflect the research problem.

7. I agree to the researcher taking my contact details (name, telephone number etc.) and contacting me during the study to arrange interview times.

8. I agree to take part in the above study.

Name of Participant _____

Date _____

Signature _____

_____ Name of Researcher

_____ Date

_____ Signature

The contact details of the lead researcher are:

Maria –Anne Moore

In Peru:

Villa El Periodista, G5, depto. 101

Wanchaq

Cusco

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Tel: +51 (0) 22 43 29

Email: mariacha@liv.ac.uk

In the United Kingdom:

The University of Liverpool

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Department of Public Health and Policy

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L69 3GL

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